Middlesex University and Metanoia Institute

Towards the integration of clinical hypnosis into an integrative relational developmental therapeutic approach: Learning from my clients

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Abstract

Aim: This study examined my former clients' lived therapeutic experiences. Clinical hypnosis was used as an adjunct to therapy in the treatment of ego state dissociations in clients that had a history of trauma - and stressor - related disorders.

Method: Ten former clients and I were interviewed and verbatim transcripts were analysed using Interpretative Phenomenological Analysis (IPA).

Findings: Five master themes emerged from analysis of the participants' interviews and two master themes emerged of the therapist's interview analysis. It was found that the therapy was experienced by the participants as beneficial. They identified a number of ways in which clinical hypnosis was used to progress therapy. The findings also showed concurrence and divergence of experiences between participants' and therapist's experiences of the participants' experiencing. The most salient ones were an experiential discord regarding the level of the therapist's emotional attunement during trance work, and on the locus of therapeutic change.

Conclusion: The study offers a range of suggestions of the potential usage of clinical hypnosis as an adjunct to therapy. It also highlights the therapist's need to develop ways of maintaining an ongoing acceptance to the clients' views and experiences during therapy.

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This research project is dedicated to:
My family – for always believing in me

1. INTRODUCTION

1.1. My interest in this area

I have encountered prejudices within the relational therapists' community concerning the use of hypnosis as a tool in the consulting room. I believe that the reason for this negative attitude towards hypnosis is that hypnosis is seen as alien to "a person in relation". I think that Buber's (1958) distinction between two modes of being in relation, "I – It" and "I –Thou", is translated into seeing ourselves, as practitioners, as either technical experts that are "doing to" or as persons in relations that are "being with". I think that prejudice, lack of knowledge, and folklore surrounding hypnosis have barred relational practitioners from considering the incorporation of clinical hypnosis into their practice, preventing their clients from accessing a unique therapeutic lever.

My interest in clinical hypnosis originated from my own personal experiences and out of my private practice. I treat clients suffering from anxiety disorders, trauma - and stressor - related disorders, obsessive - compulsive disorders, and eating disorders that typical meet diagnostic threshold of DSM-5 (American Psychiatric Association, 2013). I work within an integrative relational developmental therapeutic framework together with hypnosis. I have been using these two approaches in combination because my clinical experience has shown me that they aid and complement each other. In my experience, working in the trance is indeed relational and dependent on the quality of the working alliance, known in the hypnosis field as rapport (Gilligan, 1987; Yapko, 2003). I have observed the profound attunement that I am required to maintain with my clients whilst they are in the trance state. My clients are, I believe, always in a medium-deep stage of

trance to ensure that their memory of the experience is intact, so ego integration, the egotization of memory material and affect elicited during the work, can take place (Watkins & Barabasz, 2008).

I consider the emotional attunement that we maintain during the therapy to be significant to my clients' positive transformations (Beebe & Lachmann, 2002; Beebe, Knoblauch, Rustin & Sorter, 2005; Schore, 2003a), in particular whilst they are in the trance state. During this work, the therapist needs to respond to the slightest breathing changes and minor inflections in the client's voice which resembles a synchronic dance. In this work I believe that the dialogue integrates metaphors, images and symbols: right brain to right brain communication. I experience a deep closeness with my clients during these interchanges, a sense of holding them tightly but at the same time allowing them room to explore freely. On these occasions I find myself reflecting on what this must feel like for my clients.

This research represents a journey that began twenty years ago with my personal therapy, which consisted of a combination of talking therapy and trance work during which I achieved closure of my bereavement process. This was related to the sudden and traumatic passing away of my mother when I was twelve years old. This sad event resulted in deep confusion, the dissolution of my family and the collapse of my assumptive world. During the trance work I was able to see my mother, converse with her and receive her love and understanding, whilst expressing to her my sadness and bewilderment caused to me by her absence. In my mind I was also able to vividly hug her goodbye and attend her funeral. This

was profoundly healing to me. It permitted me to integrate trauma and achieve closure on a delayed bereavement process twenty five years after the events. My life circumstances steered me and still steer me towards learning about counselling psychology and psychotherapy in the healing of trauma and childhood bereavement. I welcomed trance work when it was offered to me as part of my therapy. I had studied hypnosis at university in laboratory conditions and I had no misgivings about it.

During my psychological counselling and psychotherapy training I met with reservation from my colleagues and some trainers regarding clinical hypnosis. This engendered a need in me to demystify it for them and others, as it has been so useful to me personally and still is in the treatment of clients in my practice. Therefore, I wanted my clients' voices to be heard detailing their experiences in therapy.

1.2. The research question

The following research questions were formulated:

- What were my clients' lived therapeutic experiences?
- What was significant in facilitating any perceived benefits or lack of it?
- What was it like for my clients to have experienced clinical hypnosis?
- Was their therapeutic process in the trance state intrinsically different to the work done in talking therapy? If so, how did these differences affect any perceived outcome?

Significance of the issue

The purpose of my research is to enhance clinicians' knowledge of the way clinical hypnosis within counselling psychology and psychotherapy may operate, as well as how or why it may be effective or not effective (McLeod, 2003). In particular I would like to contribute to the field of counselling psychology and psychotherapy by:

A) Expanding the therapist's understanding of the client's experience in therapy where hypnosis is used regularly. This study will contribute to the integration of the field of clinical hypnosis into humanistic psychological practicing. Ideally, the findings will be transferred to other settings similar to mine. The report will also contribute to the field by facilitating future qualitative research projects that focus on integrating clinical hypnosis in other clinical settings.

B) Producing a phenomenological study in which the task of learning from my own clients' lived therapeutic experiences is undertaken beyond the anecdotal. Therefore, it will provide an example for other counselling psychologists and psychotherapists who may want to systematically investigate their own practice.

1.3. Structure of the report

This report is written in seven sections. Section 1 is the introductory section as above, followed by Section 2 which describes hypnosis and the concept of trance within the integrative therapeutic framework experienced by the participants, outlining the theory that underpinned their therapy. Section 3 consists of a review of the literature. Firstly it positions clinical hypnosis historically and assesses the impact of hypnosis knowledge on clinical work. Secondly, it presents research

studies that show the need to consult clients about their therapeutic experiences, stressing the importance of carrying out qualitative research in clinical hypnosis, counselling psychology and psychotherapy. Section 4 presents the study's methodology. It describes a pilot study and explains the rationale for choosing Interpretative Phenomenological Analysis (IPA) as the method of approaching the participants' therapeutic experiences. It also delineates the participants' recruitment process, and the ethical considerations which arise when one seeks to learn from one's own clients. Section 5 contains the Analysis Outcome, the findings. First it presents the results of the Interpretative Phenomenological Analysis of the ten participants' experiences of psychotherapy. It is followed by the results of my interview: a generic interview with me as the therapist of the participants. Section 6 is a reflexive section regarding my interview as the therapist to the participants and my own process. It also focuses on my learning from this research process. Section 7 is the Discussion section. The findings are discussed in terms of their clinical implications for counselling psychology and psychotherapy. These are evaluated in terms of linking the outcomes in the data to research and clinical experience. This is followed by an assessment of the study's limitations and explores possible future research. Section 8 sets out the conclusions. It connects the project with the overall field of counselling psychology and psychotherapy.

2. HYPNOSIS WITHIN MY THERAPEUTIC FRAMEWORK

2.1 Hypnosis and the concept of trance

Since the nineteen century there have been many attempts to define hypnosis and many theories have been formed. The content of these theories have been shaped by the influence of different schools of psychological thought, and so hypnosis has been looked at through different lenses that reflect the theoretical divisions that integrative practising aims to resolve. It aims to resolve these divisions because it is considered that human beings are too complex to be explained by a single system of thought.

These hypnosis theories can be classified into physiological, such as Crawford (2001) and Gruzelier (2006) and psychological theories. The latter can be sub-divided into social-psychological and psychoanalytical theories. The social-psychological theories of hypnosis emphasise role definition, expectation, and subject motivation such as the theories presented by Barber (1969), Kirsch (1991) and Spanos (1991). The psychoanalytical theories, for example in Fromm (1979, 1992) focus on hypnosis as a regressive state. Some of the hypnosis theories have been supported and replicated by hypnosis research, while others have been found to be erroneous. I will not describe many of these theories in detail because they are not relevant to the research question.

The major difficulty in defining hypnosis is its intangibility as a state and the different individual perceptions regarding the extent to which consciousness was altered (Abela, 2000). On the one hand, hypnosis has traditionally been defined from the "state" theorists, as an altered state of consciousness or a changed state

of awareness (Hilgard, 1977; Nash & Barnier, 2008). An altered state of consciousness has been defined as a qualitative alteration in the overall pattern of mental functioning, such that the experiencer feels her consciousness is radically different from the "normal" way it functions (Tart, 1972). Such is the definition put forward by Barabasz & Watkins (2005):

> 'Hypnosis is a distinct psychological state characterized by focused attention allowing one to dissociate perceptions and sensations, to attend with intensity and precision to thoughts and events, and to rally innate resources in unusual ways.*'* (p 56)

On the other hand hypnosis has been defined by the "non state" theorists, as a social psychological phenomenon. A sociocognitive theory that describes hypnosis as a phenomenon related to attitudes, beliefs, imaginings, attributions and expectancies, shaped by hypnotic phenomena (Kirsh & Lynn, 1995).

Whether or not hypnosis involves an altered state of consciousness has been a recurrent question in the area of hypnosis. Psychologists surveyed in the Division of Psychological Hypnosis of the American Psychological Association agreed that hypnosis does entail an altered state of consciousness (Kirsch, 1993). Yet the Division developed a definition that did not mention an altered state of consciousness:

> 'Hypnosis is a procedure during which a health professional or researcher suggests that a client, patient, or subject experience changes in sensations, perceptions, thoughts, or behaviour.' (American Psychological Association Division of Psychological Hypnosis, 1993, p7)

The British Medical Association (BMA, 1955) defined hypnosis on the basis of its measurable psychological and physiological changes:

> 'As a temporary condition of altered attention in the subject which may be induced by another person. In which a variety of phenomena may

> appear spontaneously or in response to verbal or other stimuli. These phenomena include alterations in consciousness and memory, increased susceptibility to suggestion, and the production in the subject of responses and ideas unfamiliar to him in his usual state of mind.' (p190)

In 1997, the United Kingdom Council for Psychotherapy (UKCP) incorporated a hypnotherapy branch of UKC. They are currently operating as the Hypno-Psychotherapy College of UKCP. They defined hypnosis in terms of a range of naturally occurring states of altered awareness which may vary from momentary distractions and absences through much enhanced states of relaxation to very deep states of inward focus and awareness (UKCP Hypno-Psychotherapy College (2012).

Holroyd (2003) reviewed the similarities and differences between hypnosis and meditation to shed light on this question. He concluded that alteration of consciousness occurs in both hypnosis and meditation. Abela (2000) reviewed the physiological evidence. He concluded in agreement with Crawford (2001) that hypnosis is an individual differences phenomenon - a state of enhanced attention. It activates interplay between cortical and subcortical brain dynamics such as both attentional and disattentional processes. Abela (2000) concluded that both dissociated control and absorption account for hypnotic responding, the main ingredients being imagery or imagination, absorption, dissociation and automaticity. He also found that high hypnotisability correlates with a greater than normal ability to access and experience affect.

Hypnotisability is a term used to describe the individual differences in response to hypnosis, defined as differences in the capacity to enter trance Hypnotisability

is considered a trait (Barnier & McConkey, 2004). It may be measured from high to low by standardized scales, such as the Stanford Hypnotic Susceptibility Scales (Weitzenhoffer & Hilgard, 1959, 1962).

Neurophysiological hypnosis research data is obtained by using a range of instruments, such as electroencephalography (EEG) measuring brain electrical activity (voltage fluctuations) along the scalp; the Evoked Potentials (EP) which measures electrical responses of the brain to a sensory stimulus; and the Event Related Potentials (ERPs), which averages EEG stimulus responses that are time locked.

Two newer instruments are known as the Positron Emission Topography (PET) and the Single Photon Emission Computer Tomography (SPECT). PET is a medical imaging technique that produces a three-dimensional image of functional processes in the body by using a radioactive tracer. SPECT is a type of nuclear imaging test that uses a radioactive tracer to show how blood flows to tissues and organ. Other instruments used are the Cerebral Blood Flow (CBF), which measures the blood supply to the brain in a given time. Such are the brain scanners, Magnetic Resonance Imaging scanners (MRI and fMRI). These measures brain activity by detecting associated changes in blood flow.

All of these instruments have permitted the investigation of the neurophysiology of hypnosis providing substantial physiological evidence in support of hypnosis as a distinct state in its own rights (Abela, 2000; Gruzelier, 2006a, 2006b9; Hoeft, Gabrieli, Whitfield-Gabrieli, Haas, Bammer, Menon, & Spiegel, 2012).

For example Kallio, Hyönä, Revonsuo, Sikka & Nummenma (2011) used a high-resolution eye-tracking methodology while presenting hypnotised participants with a set of well-established oculomotor tasks that trigger automatic eye behaviour. They found that the hypnotic glazed stare was accompanied by objectively measurable changes in automatic reflexive eye behaviour that could not be imitated by non-hypnotized participants. In the field of hypnosis research this result suggests that hypnosis can no longer be regarded as mental imagery that takes place during a normal waking state of consciousness (Kallio et al., 2011).

Spiegel (2007) considers hypnosis to be a natural psychobiological phenomenon that involves a psychological shift in concentration, which activates a pre-existing neurophysiologic circuitry that occurs when there is synchrony between biological and psychosocial components. Erickson's approach to hypnosis emphasises an interpersonal relationship characterised by a principle of cooperation between client and therapist (Erickson & Rossi, 1981). Gilligan (1987) based on the Ericksonian approach, considers clinical hypnosis to be "an absorbing interactional sequence that produces an altered state of consciousness wherein self-expressions begin to happen automatically i.e. without conscious mediation" (Gilligan, 1987: xiii).

I believe that all of the above mentioned definitions are correct and add something to what happens in hypnosis. I consider that Spiegel, Erickson and Gilligan's stance, in particular, expand on the previous definitions because the

former highlight the psychobiological connection of the experience and the latter the interaction between the client and the therapist.

Expanding on the multidimensional factors in hypnosis Kallio & Revonsuo (2003) proposed an integrative multilevel framework of explanation that integrates the different dimensions of human experience that are present in hypnosis:

-The social-psychological level (e.g. social roles and compliance).

-The personal level (e.g. behaviours mental state, belief and desires).

-The phenomenal level (e.g. the subjective experience such as feeling heavy).

-The cognitive level (e.g. dissociation).

-The neural level (e.g. the neural correlates to the phenomenal and cognitive level such as increase in theta brain's waves activity). They proposed that the disagreement between the 'state' and 'nonstate' view is about the level of description at which the phenomenon 'hypnosis' should be conceptualized.

For the purpose of this research, the concept of "trance" is used to name the "state" of inner absorption, a highly focused mental condition which I believe activates a pre-existing neurophysiologic circuitry that can be accompanied by a changed state of awareness and involves bodily relaxation within the therapeutic encounter. This is the state during which the client experiences hypnotic phenomena. I believe that Gilligan's (1987) distinction between trance as the experience and hypnosis as the social ritual to guide the experience is helpful. The procedure always consists of induction, deepener, therapy and disengagement. The clients experience a traditional hypnotic induction, such as eye fixation (Edgette & Edgette, 1995; Spiegel & Spiegel, 2004). The protocol

of induction is followed by the next level of the process of hypnosis, which is called the "hypnotic deepener" (Edgette & Edgette, 1995). This is achieved again through traditional methods.

I am using two meanings of the word "traditional", the first as given by Yapko (2003:289), "to describe induction techniques that have been effectively used for a very long time". The second meaning of "traditional" that I use is the method of induction and deepener associated with a traditional model of hypnosis.

In this model the process of induction and deepener is an overt directive, such as counting from ten to one whilst giving suggestions related to body relaxation and deep breathing. I use the traditional model of trance induction, deepening and waking up so that the clients have a clearly defined therapeutic interaction during "trance working", which is clearly different to when we are not working in the "trance" but doing talking therapy in the same session. Once the clients have achieved "trance state", the therapy proceeds by using indirect suggestions based on non-traditional models of hypnosis, which consist of tailoring the work to the client's inner reality to access and utilise internal resources through the use of hypnotic phenomena (Erickson, 1980; Erickson & Rossi, 1981). All hypnotic phenomena can be found in naturally occurring daily experiences and are commonly observed in most psychotherapy. It is argued that this phenomena is different in hypnosis, in psychopathology and when produced by drugs, by degrees but not in kind (Yapko, 2003). Table 1 shows some of the classical hypnotic phenomena.

Table 1. Classical hypnotic phenomena

Phenomena	Definition	What it involves
Dissociation Janet (1889). Gilligan (1987). Hilgard (1977, 1992). Spiegel (2005).	A division of the personality or of consciousness or of a systems of ideas & functions. A separation of psychological states, thoughts, behaviours, feelings, body, parts.	It involves the suggestion to separate self parts to: - experience them fully - to observe them - or interact them with other parts.
Age regression Edgette & Edgette (1995). Janet (1889, 1925). Weitzenhoffer (2000). Yapko (2003).	Reverting to some method or form of expression that belong to an early phase of development. Going back in time, in place and in memory.	It involves guiding the client to past experiences or the spontaneous visiting of past experiences.
Revivification Janet (1889, 1910). Fromm & Shor (1979). Yapko (2003).	Reliving a past experience.	It involves reliving the experience as if it was happening in the here and now.
Age progression Edgette & Edgette (1995). Waxma (1998). Yapko (2003).	The projecting of oneself to the future.	Guiding the client into the future. Imagining & experiencing the consequences of current or new choices, integrating meaning, rehearsing new patterns of thoughts, feelings or behaviours.
Amnesia. Edgette & Edgette (1995). Janet (1889; 1925). Yapko (2003).	Forgetting something.	Involves accepting the suggestion of loss of memory.
Hyperaesthesia & paraesthesias Hilgard (1976). Yapko (2003).	It refers to the sensitivity to physical sensations. The subjective sensorial experience can be increased or diminished.	Increasing or diminishing the perception of sight, hearing, smell, taste or touch, temperature & pain.
Analgesia & anaesthesia Hilgard (1976). Yapko (2003.)	Analgesia refers to a reduction in the sensation of pain and anaesthesia refers to complete or near complete elimination of sensations in all or part of the body.	It involves accepting suggestions to alter the perception of pain.
Hallucinations Edgette & Edgette (1995). Yapko (2003).	Defined as delusions of the senses. Can be positive or negative. Positive: perceiving something that isn't there. Negative: failing to perceive something that is there.	It involves accepting suggestions of a perception of an object, person or situation that does not exist. Or accepting suggestions not to perceive something that is there.
Hidden observer Hilgard (1979).	It is in the mind, an analytical observer of the self.	Observes all aspects of the self's experience including pain.
Alterations in the involuntary movements of muscles, organs & glands. Edgette & Edgette (1995). Waxma (1998).	Altering body activities that are controlled and regulated through the thalamus and the autonomic nervous system. E.g. fear increases secretion of adrenaline and causes a more rapid heartbeat.	Altering the psychosomatic connection by suggesting changes in emotional states and or influencing the activities of organs and glands.

2.2 My therapeutic framework

The participants in this study received therapy within my therapeutic framework, which I describe as integrative relational and developmental. I understand the concept "integrative" as my overarching conceptual therapeutic model that finds coherence in a relational developmental stance, which is informed by theory and research from five main streams of psychological knowledge: humanistic, psychodynamic, cognitive behavioural, neuroscience and hypnosis. My approach is dynamic and ever evolving out of a process of practice-led, theoretical, research learning and reflection.

My therapeutic framework is based upon a humanist philosophy: I consider that each person is valuable, unique and in many ways unfathomable to others or themselves. I am influenced by phenomenological philosophers. In particular by the ideas of Husserl (1952), Heidegger (1949, 1962) and Merleau-Ponty (1962, 1964). The phenomenologists' thoughts are at the roots of the ideas of co-creation between observer and observed, and indeed of all relationships.

I describe my therapeutic approach as "relational" because at the heart of my approach I place an overarching theory of change in therapy, based on the healing quality of a good therapeutic relationship (Horvath, 2005; Norcross, 2011; Norcross & Wampold, 2011). This is rooted in the understanding of the relational basis of the self formation (Kohut, 1971; Kohut & Wolf, 1978; Schore, 1994, 2003a) together with attending thoughtfully to individual differences and client's characteristics such as the client's strength and preferences (Hubble, Duncan, Miller & Wampold, 2010; Cooper & McLeod, 2011).

In this model I integrate clinical hypnosis. I believe it acts as a process of co-creating states of consciousness with another person within a therapeutic relationship. This is for the purpose of facilitating the client's therapeutic processes, through the use of hypnotic phenomena.

I believe that clinical hypnosis allows in particular a controlled widening of the window of a client's affect tolerance whilst carefully monitoring the client's arousal level. This is that affects can be experienced and processed safely and effectively (Ogden, 2009; Siegel, 2012).

My model is also "developmental" as it is underpinned by neurobiological developmental evidence alongside attachment, relational psychodynamic and self Psychology concepts. The self is at the heart of my approach (Kohut, 1971). It involves the phenomenological experience that entails a sense of self as "I", a subject and the agent. The "I" that constructs a self concept of "me", as well as self knowledge through the feedback from others (Aron, 2000), and the mental representation of the self as it operates in the world. Within my approach I aim for the client to become aware, work through and integrate all her different self experiencing. In this framework I incorporate clinical hypnosis.

The provision of a secure holding environment is suggested to be essential to the development of a child's sense of self (Winnicott, 1990, 2006). I consider the need to relate, including the needs of stimulation, recognition, contact and meaning, as an inborn survival drive (Bowlby, 1979, 1988; Stern, 1985, 2003).

Subsequently the need to love and be loved, to feel accepted, to belong and to feel worthy can be seen as basic emotional needs. Social contact is the means by which these needs are met. These drives move us from birth towards the creation of intersubjective relatedness experiences that contribute to generating the phenomenology of selfhood. I see healthy relatedness as linked to the ability to move between connectedness and separateness from others.

I understand that we are also motivated and influenced by the internal dynamics of the subconscious. I think that complex subconscious processes influence emotional experience and overt behaviour. Pierre Janet (1889) introduced the term subconscious as he thought the term unconscious was inaccurate. I share Heidegger's (1949, 1962) ontological perspective. I consider that the subconscious is not a theoretical construct, nor is it just "in" my head, but "out" there, in the world, as a dimension of "being". Heidegger (1962) concluded that there are levels of experience just as there are levels of consciousness depending on my capacity to interpret in depth what my experience is disclosing to me. I also believe that the boundary between what is conscious and what is subconscious is fluid and context dependent. I see the purpose of therapy as not to finally "know" the subconscious, but to return the clients to the ground of an experience from which they have lost their way, in order to claim it as their own. I also agree with Heidegger (1962) that there is not one state of consciousness but different levels of consciousness that can vary many times during our waking hours and are context dependent (Spiegel, 2005). This is linked to our interactions with our psychosocial environment and the affective pulse of our inter-subjective and intra-psychic field. Thus, it is argued that there is no such entity as

consciousness, but we are from moment to moment differently conscious (Hughlings-Jackson, 1931).

Neuroscience tells us that the first years of life are a critical period in the formation of the self. This developmental process is significantly influenced by the child's affective interactions with the primary carers from birth. It has a profound impact in the later self-regulatory coping mechanism (Cozolino, 2006; Hart, 2008; Schore, 2009) and in the development of the self reflective function (the capacity to mentalize) (Fonagy & Target, 1997; Fonagy, Gergely, Jurist, Elliot, & Target, 2004). I think that the formation of the self is not limited to childhood; neuroscientists tell us that the capacity for experience-dependent plasticity changes in the nervous system remains throughout our life span, allowing a dynamic self to develop in a non linear manner to an ever-increasing level of complexity (Siegel, 2012).

However I understand that the first years of life are critical in the self formation. It is suggested that repeated interactions with primary carers are internalized into "internal working models", originating styles of relatedness that are thought to shape our conscious and unconscious belief and experiential system (Ainsworth, Blehar, Waters, & Wall, 1978; Main, Kaplan & Cassidy, 1985; Stern 1985, 2003).

I understand these internalized relational schemas as organised into "self-state". This refers to discrete experiences of subjectivity created when the brain links co-occurring somatic, affective, cognitive, and behavioural experiential patterns into cohesive ego states (Siegel, 2012). These repeated experiential patterns create the

fundamental basis for the structure of personality that at a very basic level derives from the neuronal connections developed out of the state-dependent learning processes (Rossi, 1986) and become "hard wired" together as a result.

Learning in this context refers to the fact that biochemical and neuronal associations are made among components of a "mental state" linking them together. These interconnected components can be conceptualised as an "ego state". These self-state (ego states) are thought to generate our subjective experience of self representation in the moment (internal subjects) (Damasio, 2000). This is in addition to our subjective experience emanating from the internalized significant others (internal objects), appraise and then regulate our response to that experience (Schore, 1994, 2003a, 2003b). Together, their relationship forms an internal attachment system whose affective quality and functional capacities will be analogous to those experienced with primary attachment figures (Schore, 2009). These self states are also thought to be generated from highly positive or negative emotionally charged experiences throughout our life span such as traumatic experiences or intensely meaningful positive experiences.

The concept of ego states (self - states) in this study is not derived from Transactional Analysis' theory. Instead it is informed from neuroscience applied to Attachment and Object Relations theory (Siegel, 2012) and the theoretical framework of the Ego States theorists that use clinical hypnosis (Phillips, 1993; Phillips & Frederick, 1995; Watkins & Watkins 1997; Watkins, & Barabasz, 2008).

Neuroscientists (Schore, 1994, 2003a, 2003b; Siegel, 2012) have highlighted the importance of the psychobiological "self state" in understanding the mind-body connection, psychological development, personality, resilience and pathology. While each ego state plays a role in self-organisation, what is most important to psychological functioning is the mind's ability to integrate activity and functions across self-states.

Different psychological theories have conceptualised in different theoretical systems how the mind attempts to create a sense of coherence among multiple selves across time and across contexts. This is demonstrated in Assaglioli's, (1975) Psycho- synthesis, Berne's (1961, 1977) Transactional Analysis, Watkins & Watkins' (1997) Ego State Therapy, Van der Hart, Nijenhuis & Steele's (2006) Psychobiological- action - system/tendencies and Bromberg's (2011) Phenomenology of Self- states. I embrace the notion of a polypsychism, that the self, the I, the ego is made up of many sub-systems within a developmental theory framework (Ainsworth & Bowlby,1965; Ainsworth, Blehar, Waters & Wall, 1978; Bowlby, 1979, 1988; Main, Kaplan & Cassidy, 1985; Stern,1985, 2003).

In clinical practice I observed that the insecurely attached clients (Holmes, 2005) present an intra-psychic relating among their ego states that repeats the disengagement, abuse and inconsistency found in their relationships with abusive and neglectful caregivers or from ego states developed out of trauma later in life. The rapid altering between poorly integrated ego states, each embodying different internal working models, provides a good explanation of the tormented phenomenology that they describe in therapy (Bromberg, 2011). The participants

of this study fall into this group. Therefore, the core of the therapeutic work with the participants focused on a phase-oriented treatment (Spiegel, 1993; Van der Kolk, McFarlane, & Weisaeth, 1996; Van der Hart et al., 2006) of healing trauma and dissociation.

3. LITERATURE REVIEW

This section first positions clinical hypnosis historically and assesses its effectiveness as a treatment modality that makes it worthy of research. Secondly, it presents the rationale underpinning the proposal that the type of research needed in order to learn from my clients' experiences of therapy is qualitative research.

3.1. Hypnosis: historical overview

Healing in the trance is one of the oldest of the medical arts; healing while in a sleep-like state has been observed in many cultures throughout the world and recorded from ancient Egypt through to Roman times and beyond.

The French neurologist Charcot (1887) - at the Salpetriere Neurological Clinic - rescued hypnosis from the esoteric that surrounded it during Mesmer's Animal Magnetism (Gauld, 1992). Charcot theorised that hypnosis and hysteria were both symptomatic of disorders in the central nervous system and although his theory was disproved he brought hypnosis into the medical profession. The golden age of hypnosis was during 1880 to 1900. During this time in France hypnosis was officially recognised by medical schools. The first International Congress of Experimental and Therapeutic Hypnotism was held in Paris in August 1889. It was attended by Pierre Janet, Charcot, Babinski, Freud, Richet, Liebeault, Bernheim, William James and many other illustrious explorers of hypnosis (Chertok, 1966). Amongst them, Pierre Janet (1889, 1925) stands out as he is considered to be at the threshold of all modern dynamic psychiatry. He coined the words and developed the concepts of "subconscious" and "dissociation".

Janet was one of the first to draw a connection between events in the subject's past life and her present day trauma. He proposed a phase oriented treatment for trauma. He established a developmental model of the mind in terms of a hierarchy of "action tendencies". Neurosis could be seen as a failure to integrate, or a regression to earlier tendencies. Janet viewed hypnosis in terms of suggestion and dissociation. He was the first to describe somnambulism as a phenomenon whereby two or more states of consciousness are dissociated by a cleft of amnesia and seem to operate independently of one another. Janet's understanding of "rapport" led him to create awareness by mirroring the patient's experiences rather than to confront them (Ellenberger, 1970).

The hypnosis development in Paris spread to other countries. James Braid (1943), a Scottish surgeon, observed that hypnotic trance could be induced by the fixation of attention on an object; he concluded that hypnosis was caused by focusing attention on one idea rather than on physiological process. He coined the term "neurohypnosis", a nervous sleep, which soon became shortened to "hypnosis", from Greek Hypnos, meaning sleep. Braid adopted the term "hypnotism" to separate hypnosis from Mesmerism, and to remove exoteric influences as the cause of hypnosis (Gauld, 1992).

Historically, hypnosis has contributed to major advances in the understanding of psychopathology by opening the field to fundamental concepts such as: dissociation, the subconscious (Janet, 1889, 1925), ego defence mechanisms, the therapeutic effects of emotional expression, and abreactions/catharsis (Freud, 1895). Other concepts include the complexities of consciousness, memory and perception (Janet, 1889, 1925), the mind body relationship, the development of

psychosomatic medicine (Janet, 1889, 1925; Sdaile) and the birth of Psychoanalysis (Freud & Breuer, 1895).

In 1895 Breuer discovered that one of his patients, Anna O, began to speak spontaneously whilst under hypnosis. She displayed a profound emotional reaction followed by the disappearance of many of her symptoms, such as various paralyses and a phobia of drinking water. This emotional response was called catharsis or a purging of the problem which had been the cause of her symptoms and had been repressed below the level of her awareness. Freud joined Breuer in investigating this phenomenon more fully and confirmed the results (Freud & Breuer, 1895). This marked a change in hypnotic therapy from the direct removal of symptoms to the elimination of their apparent causes.

Anna O. was Freud and Breuer's first written case study during which the phenomena of conversion and transference were discussed. The need to explain it to the patient as a way of "interpretation" became part of the therapy, setting the foundation of psychoanalysis. It was believed that if hypnotic access to repressed subconscious memories was followed by catharsis, the releasing of the original emotions, the physical symptoms would disappear.

Freud experimented with hypnosis extensively but was not able to repeat the dramatic results of Anna O. By 1896 he had abandoned hypnosis for free association, which Anna O called "the talking cure", and dream analysis as his tools for accessing the subconscious. He was disappointed that he could not bring with hypnosis a permanent cure to hysteria. It has been reported that personal and clinical factors contributed to Freud's dismissal of hypnosis as a tool to access the

subconscious. One of the factors put forward was that he was not a good hypnotist. Among other things, his method for inducing hypnosis was a deficient one, which consisted of making passes over the patient's head and upper body. Freud found he was stared at by his patients for hours every day and he did not enjoy it (Ellenberger, 1970; Waterfield, 2002).

There was a decline in the use of hypnosis subsequent to the Freudian rejection of it. However the major decline began with the death of Charcot in 1893. Janet was the only one of his contemporaries to maintain interest in hypnosis. He believed that the decline of hypnosis was only a transient eclipse and he was right (Janet, 1925). During the First World War a demand for a much abbreviated form of psychotherapy emerged. Soldiers were returning home suffering from "battle fatigue", post traumatic stress disorder (PTSD). Hypnotherapy was once again used by the medical profession in order to treat this. It was used for direct removal of symptoms, relieving war neuroses and pain (Watkins, 1949; Waxman, 1998).

The psychoanalytical abandonment of the clinical uses of hypnosis in the consulting room relegated hypnosis to the other stream of thought in psychology that existed at the time, namely Behaviourism (Pavlov, 1923, 1927; Watson, 1931; Skinner, 1953). It was in the nature of the learning theorists to study hypnosis in rigorous laboratory controlled conditions, within the stimulus-responses remit. Therefore, the phenomenology of hypnosis was completely ignored. The Russian neurologist Pavlov (1923) defined hypnosis as a response to classical conditioning. Pavlov postulated that hypnosis was a classically conditioned

response of the brains that involved selected areas of cortical inhibition (Pavlov, 1923).

Since the first quarter of the nineteenth century, hypnosis research developed slowly, initially through the experimental work of Hull (1933) followed by the experimental work of Hilgard, (1979, 1992). Hilgard (1992) developed his influential neodissociation theory of hypnosis, according to Hilgard consciousness consists of both an executive function and a monitoring function. Under hypnosis, consciousness can be controlled so that some aspect of experience (e.g. pain) may be kept dissociated from conscious awareness, or so that some aspect of the experience already dissociated from consciousness (e.g., implicit traumatic memories) might be accessed without overwhelming affect.

Hypnosis has increasingly become the subject of serious scientific inquiry. Most hypnosis research has been quantitative in approach and has been applied mostly in the fields of medicine and dentistry (Waxman, 1998). Clinical hypnosis as a field had been developing progressively since 1955 when the British Medical Association (BMA) recognised hypnosis as a valuable therapeutic modality (BMA, 1955). In 2002 the University of Oxford Medical School was the first medical school in the UK to offer a clinical hypnosis module as special study option within its undergraduate programme. Since then it has been introduced in most medical schools in the UK (James, 2010).

3.2. Hypnosis effectiveness

The BMA's stance on hypnosis generated much empirical research and clinical practice on medical hypnotherapy. This research highlighted some areas in which

hypnosis has been described as an effective tool for treatment. These are: the alleviation of pain, in the management of chronic and acute pain (Brown, 2005; Elkins, Jensen, Patterson, 2007; Hammond, 2007; Nash &Tasso, 2010); pain relief in surgeries (Albrecht & Wobst, 2007; Hammond, 2008); cancer care (Liossi, 2006); the treatment of psychosomatic disorders such as, irritable bowel syndrome (Barabasz & Barabasz, 2006), human papillomavirus (Barabasz, Higley, Christensen, & Barabasz, 2009), asthma (Hackman, Stern & Gershwin, 2000), and headaches and migraines (Hammond, 2007).

Flammer & Alladin (2007) conducted a meta-analysis with 21 randomized, controlled clinical studies to evaluate the effectiveness of hypnosis as an adjunct to therapy in the treatment of psychosomatic disorders, and concluded that hypnotherapy is highly effective. Furthermore, on the 6 June 2011 the Psychosomatic Medicine Section of the Royal Society of Medicine (RSM, 2011) stated that hypnosis treatment should be available under the National Health Service (NHS). They declared to the newspapers that:

> 'Hypnosis treatments could be used on a range of medical conditions, including pain management and stress to save the NHS millions of pounds, according to a group of medical experts.' *(*Owens, 2011*)*

Hypnosis has also been described as an effective treatment modality in the treatment of a range of psychological conditions such as depression (Alladin, 2009; Yapko, 2010), identity personality disorder (Van der Hart et al., 2006 Watkins & Barabasz, 2008), obsessive compulsive disorders (Frederick, 2007), post traumatic stress disorder (PTSD) (Cardenas, Maldonado, Van der Hart, Spiegel, 2009; Vermetten & Christensen, 2010), phobias (Wolpe, 1958,1982), and anxiety and stress-related disorders (Bryant, 2008; Straub & Straub, 2009). Gould & Krynicki,

(1989) found hypnosis effective in reducing levels of anxiety and in particular, anxiety manifested through bodily symptoms. They noted that the symptoms most associated to the "fight-flight" reaction respond most readily to hypnosis.

Flammer & Bongartz (2006) carried out a meta-analytic study on the effectiveness of hypnosis as a treatment tool. They selected 57 randomised controlled studies of the best quality research designs for meta-analysis. They concluded that hypnosis was an effective treatment modality in the treatment of psychosomatic illness, addictions, anxiety disorders, test anxiety, smoking cessation and pain control during orthodox medical treatment. Cooper (2008) carried out an overall review of hypnotherapy and concluded that hypnosis is an effective adjunct to therapy; he reviewed some of the above mentioned studies and added that hypnosis has also been shown to enhance the effectiveness of Cognitive Behavioural Therapy (CBT) (Bisson, 2005).

I believe that research is suggesting that hypnosis can be an effective treatment tool for a range of conditions. However, it would appear that further randomized controlled outcome studies are needed for extended generalisation of findings, and also longitudinal studies in order to ascertain if the described improvements are long lasting. In my view, the published clinical work and research suggests that clinical hypnosis is a valuable treatment modality, and is highly adaptable to the multiple manifestations of stress and anxiety in illness. Consequently, it would seem to be a legitimate subject for systematic enquiry in the field of counselling psychology and psychotherapy. This view was confirmed by the British Psychological Society (BPS), in a report entitled "The Nature of Hypnosis" (2001),

that concluded: “hypnosis is a valid subject for scientific study and research and a proven therapeutic medium” (p1).

3.3. Hypnosis in psychotherapy

In a parallel process to research, the clinical practice of incorporating hypnosis as an adjunct to therapy has been developing steadily. It has acquired recognition by accredited bodies such as the UKCP. In 1997, UKCP formally endorsed the new term “Hypnopsychotherapy”, meaning "the branch of psychotherapy which uses hypnosis" and created a section within the Council for Hypnopsychotherapy currently named as The Hypno-Psychotherapy College of UKCP (UKCP Hypno-Psychotherapy College).

In the last three decades hypnosis as a therapeutic tool has been filtering into many psychotherapeutic clinical practices inspired by Milton Erickson’s work in the USA (Erickson & Rossi, 1979, 1981). It is currently used as a tool by practitioners from all theoretical perspectives, including: psychodynamic, cognitive-behavioural, solution-focused, existential, gestalt and transpersonal approaches (Fitzgerald-Pool, 2005). The way that hypnosis is integrated within a clinical practice depends on the model of the individual therapist (Fitzgerald-Pool, 2005). For example, the integrative mind body therapist Ben-Shahar (2008), integrates attachment based psychoanalytic psychotherapy, body psychotherapy and hypnotherapy. Conversely, the Gestaltist Kepner (2003) uses hypnosis to create a “safe space” in the work with trauma clients. According to Kepner (2003), hypnosis helps clients to cope with overwhelming emotions in times of stress. He argues that: “this method takes advantages of the often natural response of dissociations, by giving the survivor a

place to dissociate to, instead of just becoming disoriented and vague" (Kepner, 2003:47). However, Kepner (2003) in his book on trauma treatment "Healing Tasks" mentions hypnosis not as a field, but as just another way of producing guided imagery.

In my practice, while I am cognisant of the many benefits related to the scope of deepening my clients' inner processes by the use of hypnotic phenomena, I am also aware of the potential hazards associated with the therapeutic usage of clinical hypnosis. Historically the main criticism of hypnosis in therapy has been the notion of "symptom substitution", which refers to the onset of new symptom, perhaps but not necessarily a worse one, in place of the old symptom removed during treatment Rosen (1960). This hazard has also been linked to behavioural therapy.

Over one hundred years ago Janet (1925) warned practitioners about the potential hazards when using hypnosis and cases of deleterious effects of symptoms removal by hypnosis has been documented. For example, Kleinhauz & Eli (1987) in an article entitled Potential Deleterious Effects of Hypnosis in the Clinical Setting discussed a client who came for smoking cessation and became extremely agitated and depressed, and experienced suicidal thoughts.

Therapists using hypnosis as an adjunct to therapy need to be aware of the mind's dynamic capacity to substitute symptoms. This capacity exists and is not negative per se. In my experience, paradoxically symptom substitution/modification has been many times a desirable part of a treatment plan; intentionally creating with the client's agreement an acceptable symptom. For example: channelling a client's physical pain from a highly sensitive part of her body to a less sensitive part.

Great care needs to be taken to understand the role of a symptom in a person life journey and their multifaceted dynamics, and there is a need to avoid the superficial use of hypnosis involving rigidly scripted approaches which may fail to take into account the role of the patient's symptoms. In my practice I conceptualise my clients' symptoms' situational within their inner and outer support system. I incorporate this within my clients' treatment plan in order to cater for the potential intra-psychic "imbalance" caused by the possible removal of a major symptom. Following a fast major symptom removal I carry out trauma treatment within my relational approach. These clients have remained symptom free without substituting the symptom(s) and were able to work through, processed and integrate experiences.

Another potential hazard that all therapists and in particular those that work with trauma have to face when using hypnosis in the sessions, is the potential of confabulations or material projected into a memory gap (Schachter, 1996). Confabulations may be self-generated or it may be a suggested memory that is incorporated as real during hypnosis. The danger is that someone will mistake a confabulation for truth (Yapko, 2003)

When using clinical hypnosis there is the possibility of spontaneous regressions and abreactions. These are all manifestations of hypnotic phenomena that can be at the same time powerful healing tool and potential hazards. Hence clinical hypnosis in therapy has to be used sensitively by properly qualified and experienced clinicians. There is a high level of consensus amongst hypnosis researchers and practitioners that hypnosis holds no inherent dangers when used appropriately by a well trained clinician (Conn, 1981). The hazards that exist are identical to those potential

hazards that clinicians can encounter in clinical practice when dealing with diverse vulnerable people in distress.

This point to the need for training programs in clinical hypnosis to promote not only the teaching of safe hypnotic usage but also the restrictions of the use of hypnosis to the areas of competency of the practitioner. It also highlights the need for national standardised guidelines for training and accreditation prior to clinical hypnosis practise, the absence of which has been harmful to the reputation of clinical hypnosis (Stanley, 1994).

3.4. Gaps in hypnosis research

Hypnosis research and the practice of hypnosis have followed mostly separate paths (Heap, 2000). Generally, the research has been carried out in laboratory studies and hospital settings seeking causal determinations, predictions and generalisations of findings (Fromm & Shor, 1979). Clinicians using hypnosis in therapy have been learning it not from research, but as a craft, using the clinical experiences of other clinicians such as Milton Erickson in America and his wide world followers (Battino & South, 2005). All the above suggests a need for practitioner research into the applicability of hypnosis in psychotherapy.

The therapists that use hypnosis as an adjunct to inform clinical practice claim that hypnosis adds particular therapeutic leverage, malleability, deepness and effectiveness, in addition to being time saving (Yapko, 2003; Watkins & Watkins, 1997). However, patients and clients have predominantly not been consulted. To my knowledge very little research has been conducted to ascertain what goes on for

clients during psychotherapy in the trance, and their opinions of what in the trance is more helpful or less helpful.

Research into the client's experience has been carried out mostly by gathering quantitative phenomenological data. It has often focused on the effectiveness of clinical hypnosis compared to other treatment methods; on differences in participant variables, such as the effect of the level of trance in the quality of performance of a range of cognitive tasks; or involved comparative studies looking into the relaxation and pain relieving properties of hypnosis. Observation of one's own mental processes has been relatively neglected in hypnosis research, despite the fact that altered states are usually first identified by subjective experiences.

The research instruments mostly used are: the Parallel Experiential Analysis Technique (PEAT) (Varga, Bannyai, Gosi-Greguss, 1994) and the questionnaire of Phenomenology of Consciousness Inventory (PCI), (Pekala, Steinberg & Kukmar, 1986; Pekala, 1991). There is also the Archaic Involvement Measure (AIM) and the parallel versions of these scales for the therapist, (AIM+H) (Nash & Spinler, 1989) and the Experiential Analysis Technique (Sheehan, McConkey, & Cross, 1978). These are Phenomenology of Consciousness Inventories, which are completed retrospectively in reference to different aspects of hypnosis.

I believe that information about inner experience is lost to us in most hypnosis studies because investigators stop at the point of identifying hypnotisability of the participants, and have not considered a qualitative approach that could provide a more in depth experiential accounts from the participants' perspective.

In the field of counselling psychology and psychotherapy there are increasing calls for practice based research on the lived experience of therapy from the client's perspective (Gordon, 2000). However, much of this data has again been gathered through quantitative measures using pre-defined categories developed by the researcher to determine satisfaction or change (McLeod 2001). The few studies that I found in hypnosis research that seek the clients' experiences fit McLeod's (2001) assertion. For example Marc, Rainville, Masse, Dufresne, Verreault & Vaillancour, (2009) investigated women's views regarding hypnosis for the control of surgical pain, in the context of a randomised clinical trial. The aim of this study was to assess women's satisfaction with a hypnotic intervention for anxiety and pain management during a pregnancy terminating procedure, in which a large sample of participants were used (N = 350). Women in the hypnosis group reported higher levels of satisfaction with the procedure. This is consistent with the growing literature in favour of hypnotic interventions to improve pain management and care.

Most of the qualitative research from the client's perspective of hypnosis relates to self-hypnosis research. These articles highlight the advantages of using self-hypnosis in the enhancement of psychological wellbeing in long term ill patients, for example in breast cancer care (Bennett, Laidlaw, Dwivedi, Niyo, Gruzelier, Johrei, 2006). An exception to this is Abbasi, Ghazi, Barlow-Harrison, Sheikhvatan, & Mohammadyari's (2009) qualitative phenomenological study, describing the effect of hypnosis on pain relief during labour and childbirth. Six pregnant women were trained to use self-hypnosis for labour. The women described their feelings whilst using hypnosis during labour as: a sense of relief and consolation, self-confidence, satisfaction, lack of suffering labour pain, changing the feeling of tiredness and lack

of anxiety. Births were perceived as being very satisfactory compared to their previous experiences.

There is an ever increasing volume of recent research in counselling psychology calling for clients to voice their experiences of therapy. The reason for this is that therapists' perceptions of what goes on for the client are not necessarily accurate. For example, Llewellyn, Elliott, Shapiro, Hardy & Firth-Cozen's (1988) study of significant moments occurring during therapy showed that aspects of the therapeutic encounter had a different degree of salience for therapists and clients. Gordon (2000) concluded:

> 'Therapists may need to become more aware of the ways in which events occurring in therapy are perceived differently by therapist and client and support the argument that qualitative research is needed to expand the understanding of the client's perspective and of the implications that this may have for the psychotherapeutic relationship.' (p9*)*

Sousa (2006) reviewed the field of outcome and process research from an existential phenomenological perspective and proposed that, in an effort to overcome the dichotomy of outcome versus process research regarding therapeutic change, the starting point to produce relevant research findings had to be a phenomenological perspective. In this, clients are considered privileged witnesses of therapeutic process and the best source of information about their therapeutic outcome. Sousa also considers the testimony of therapists to be valuable in collecting information on the dyad and only in a second phase it is considered from the perspective of a third party, the trained raters (Sousa, 2006). Hence the present study aims to use clients' and therapist's account of therapy.

There is phenomenological research showing how clients' perception of their therapy can differ from their therapists' perception and expectations. This research has been

from a family therapy perspective (Howe, 1989). However, the majority of the research has been carried out from a Person Centred perspective. Such is the work of Rennie (1990, 2001), who has carried out qualitative research aimed at investigating the client's process in therapy, using interpersonal process recall methodology. From this research, a core category that pervasively arose was that of the client's self-awareness and self-control. Rennie (2001) termed it the client's 'reflexivity'. This reflexivity is seen as an active process of the client choosing how to engage with therapy. Significantly, reflexivity is not always verbalised. This can lead to situations where clients outwardly refer to the therapist, but may inwardly be working towards their own solutions to their problems.

Schnellbacher and Leijssen (2009) studied "The significance of the therapist's genuineness from the client's perspective". In this research both qualitative and quantitative data were gathered. The authors analysed clients' opinions on the overall significance of therapist genuineness in their therapy. They found that clients also experienced processes other than genuineness as crucial therapeutic processes. There seems to be a steady stream of research showing that the client's views of their own therapy can be different to the therapist's perceptions and expectations.

It has been found that it is vitally important for therapists and researchers to listen to clients and to examine their practices and theoretical approaches in the light of their clients' experience of them (Bohart & Tallman, 1999, 2010; Mackrill, 2008; Duncan, Miller, Wampold & Hubble, 2010). These studies show the centrality of the client's perceptions to achieving a successful outcome. It demonstrates that clients are actively involved in their therapy, making counselling work even when their

counsellors are insisting on a way of working that the client disagree with. According to Singer (2005):

> 'These studies suggest that clients may not experience therapy as beneficially as traditional outcome studies indicate. This raises a new challenge to researchers to more fully explore the client's experiences of therapy, a challenge to which qualitative methods that focus on the clients' lived therapeutic experience would appear well suited. The research shows that clients are active in making their therapy work. That what clients considered pivotal in having an impact in their therapy is not the same as what is considered by their therapists.' (p280)

Outcome research shows that the majority of clients undertaking therapy make significant improvements; yet understanding why and how therapy works is limited (McLeod, 2001). The healing quality of a good therapeutic relationship appears to be a critical factor (Wampold, 2001), linked to the importance of attending closely to patient factors such as patient strengths and preferences (Cooper & McLeod, 2011).

The Boston Change Process Study Group (BCPSG, 2010) has looked closely into the therapeutic relationship and the process of change in psychotherapy (BCPSG, 2010). They concluded that the therapeutic relationship is a specific modality of treatment that is necessary for change. They also found that specific technical activities may help certain patients or the same patient a great deal at different times. However, they found that the therapeutic relationship is always there, "moving along". In particular when there is an engaged search for directionality and fittedness in a creative regular negotiation between the client and the therapist.

Focusing on this engaged search for directionality and fittedness, Cooper & McLeod (2011) proposed the notion of pluralistic counselling. This is a framework for therapy which emphasises the development of a collaborative relationship between client and therapist, in which they work together, co-constructing a method that facilitates the identification of therapeutic experiences and factors that are likely to be helpful to the client. They implement these factors to produce positive change in the direction of the client's goals. The emphasis is in the centrality of the two-person psychology in the process of therapeutic change.

Information from clients' accounts of their experiences is vital to our understanding of all of the above and yet is often overlooked in research (Paulson, Everall & Stuart, 2001). This seems to be particularly so when clinical hypnosis is used and especially when it is used within integrative approaches to therapy. I believe that as a result of this failure to attend to the client's phenomenological experiences, we are missing crucial information that could help us understand what actually goes on for the client during therapy in hypnosis. Woodard's articles (2003, 2004 & 2005) make a case for the need to carry out more qualitative phenomenological research in order to develop a more comprehensive understanding of hypnosis. He advocates that hypnosis is fundamentally a process of differentiating personal meanings, that it is as unique as the individual differences naturally occurring, and that qualitative research will enhance our understanding of hypnotic experiencing. I think that the consumer's view of therapy is needed in their own voices. This is a gap that this study seeks to fill.

4. METHODOLOGY

4.1 Study design

In this chapter, I describe first the rational that led to the selection of a qualitative methodology, namely Interpretative Phenomenological Analysis (IPA). This is followed by a presentation of how a pilot study influenced the study's design. It continues with a description of the criteria used for the recruitment of the participants. This is followed by an outline of how trustworthiness was addressed, and how ethical issues were considered. It concludes with a description of the methods used to store and analyse the data.

4.2 Why IPA?

The aim of this study is to learn from my former clients what the experience of clinical hypnosis was like for them and what it meant to them to have experienced clinical hypnosis within my therapeutic approach. In designing this study, I chose IPA as a methodology that would allow me to explore my clients' experience in depth, drawing out similarities and differences between their accounts, while also acknowledging my own role in interpreting the data.

In terms of my ontological and epistemological position, I consider that there is no objective reality to be uncovered when studying people's experiences and it associated personal meanings. I consider that human beings are inherently engaged in creating meaning as an inter-subjective phenomenon, constructing reality in interaction with the world, and one another. Thus, a person's subjective reality is fluid and constituted in and of the moment as it is lived. Within this

conceptual framework I place the researcher and the researched as living experiencing human beings of equal standing in the world. This idea leads me towards the epistemology of phenomenology and hermeneutics.

Phenomenology comes from the Kantian concept "phenomenon", to show itself in itself. In research, phenomenology is used to seek the core of the experience. It involves an in-dwelling in the phenomenon until its essential features reveal themselves. According to Van Manen (1990), anything that presents to consciousness is potentially of interest to phenomenology, whether the object is real or imagined, empirically measured or subjectively experienced. Emmanuel Kant (1781) distinguished between two forms of reality. Noumenal reality refers to things in themselves, and phenomenal reality is the appearance of things as they are perceived, conceived, thought of and interpreted. Phenomenologists studied the perceived world because the noumenal world was thought to be inaccessible.

My aim of exploring the lived therapeutic experience of my former therapy clients is in accord with the phenomenological movement's recognition of the centrality of the "lived world" in which individual engage in particular subjective ways of relating to their world. My research project fits with the exploratory nature of this philosophical current of thoughts that consist of focusing on experience per se and its perception (Husserl, 1952). For this research project it means accessing the experiential content of the participants' consciousness: 'the things themselves' (Husserl, 1952).

I considered that the concept of epoché in phenomenology would illuminate my insider researcher pathway, given that epoché requires the researcher to set aside

preconceived ideas and assumptions in the interest of returning to 'the things themselves'. Husserl (1952) proposed setting aside one's presuppositions and views in order to mitigate any undue influence on the research process. However, Heidegger's (1962) offers an interpretative phenomenology that favours the idea that "lived experience" is, in essence, an interpretative process and totally "bracketing out" preconceptions is not possible.

Schleiermacher (1805) opened up the idea of hermeneutics as a theory of interpretation. Hermeneutics considers that understanding is always from a perspective and always a matter of interpretation (Schleiermacher, 1998). Phenomenology becomes hermeneutical when its method is taken to be interpretive rather than purely descriptive, as in Husserl's (1954) transcendental phenomenology.

This current of thought is apparent in Heidegger's hermeneutic phenomenology (1949, 1962), who argues that all description is already interpretation and every form of human awareness is interpretive. The notion of hermeneutic understanding for Heidegger was not aimed at re-experiencing another's experience but rather to grasp one's own possibilities for being in the world in certain ways. To interpret a text is to come to understand the possibilities being revealed by the text. In a related way, my research project purpose is to develop an understanding of the sense that my former therapy clients make of their lived therapeutic experiences.

I acknowledge that it encompass an awareness of offering an outlook on their accounts that goes beyond the overt content. Consistent with Heidegger's interpretative phenomenology (1962), I understand my interpretative part when examining my participants' accounts as requiring my candidness towards their reports and also containing my own understandings. Drawing on Heidegger (1962) and Gadamer (1998), I recognise that inherent in any interpretations are the presence of fore-structures: assumptions and pre-conceptions. In interpreting a text we cannot separate ourselves from the meaning of a text: that understanding involves an interpretive dialogue, which includes taking up the tradition in which one finds oneself. In contemporary research McLeod refers to this process in terms that the researcher can never be free of pre-understandings or prejudices that arise from belonging to a culture and language (McLeod, 2011).

In Gadamer's (1998) hermeneutic philosophy this is conceptualised in terms of horizons. Horizons are formed by our own assumptions, pre-suppositions and preferences. These for-structures make up our own horizon of understanding, and are unavoidably present when we meet another person. If our horizons overlap then we can make ourselves understood and understand the other. For Gadamer (1998) this fusion of horizons is effected by first making ourselves more transparent. Finlay (2003) clarifies Gadamer's theory:

> 'Our understanding of the "other-ness" arises through a process of making ourselves more transparent. Without examining ourselves we run the risk of letting our un-elucidated prejudices dominate our research. New understanding emerges from a complex dialectic between knower and known; between the researcher's past pre-understandings and the present research process, between the self interpreted co-constructions of both participant and researcher.' (p108)

In line with Gadamer (1998) I recognise that the process of reflexivity is a

fundamental element in making me more transparent. Consequently, I consider that the methodology I selected needs to allow the self-reflexive process to be interwoven into the fabric of the research, as it would assist me to contest with my for-structure while in awareness that these can enhance or hinder the trustworthiness of my endeavour.

Heidegger (1949, 1962) highlighted our embeddedness in the context of the world, and contended that we have the capacity of agency and the skills to make sense of experiences and each other. However, we do this within the limitations of the world we live in. Heidegger's (1949, 1962) understanding of the contextual embeddedness supports my interest in understanding the nature of my former clients lived experiences in therapy. I recognise that the methodology that I require must encompass an interpretativist paradigm to cater for my own conceptions that come from my own embeddedness in the psychosocial world that I inhabit. It also must include wider latitude for phenomenological exploration and analysis of profound inner meaning of lived experiences.

I chose IPA because the philosophical foundations of IPA are compatible with my research question and my epistemological position. It is underpinned by phenomenology, hermeneutics and ideography (Smith, Flowers & Larkin, 2009). The idiographic quality of IPA offers me an adaptable approach to phenomenological research that allows an in depth account that privileges the individual. IPA requires an in-depth analysis of aspects of the reflected personal experience (Smith, 2008). IPA also makes sense of these experiences from a psychological perspective through the interpretative aspect (Larkin, Watts & Clifton, 2006; Smith, et al., 2009). The interpretative element of IPA is

intellectually connected to hermeneutics and theories of interpretation (Larkin et al., 2006; Smith & Osborn, 2008). IPA aims to capture the experience of individuals as they themselves have constructed it but through the lens of the researcher. In line with Gadamer's (1998) notion of horizons, IPA recognises the significance of the researcher's fore-structures - assumptions and pre-conceptions and that they can both hinder and enhances the interpretations of another's lived experience. The outcome of this interpretative dialogue between research and researched is conceptualised as double hermeneutics. The researcher makes sense of the participants' making sense (Smith et al, 2009).

I accepted that my analysis of the data or "my making sense of the participants making sense" would be influenced by my previous experience as the effect of fore-structures was inevitable. However, I also believed that the awareness of this influence on the interpretation was essential to the trustworthiness of my findings. This heightened the centrality of the self reflexive task during the research project, and I aimed for personal transparency.

IPA has been criticized as a too subjective methodology that produces data that cannot be replicable and therefore considered as not meeting the generally accepted scientific criteria (Giorgi, 2011). However, I consider that IPA was the most appropriate qualitative methodology available for my particular research project as it honoured the co-created nature of the exploration of lived experience between the researchers and researched.

I considered other methods of enquiry within the qualitative field before choosing Interpretative Phenomenological Analysis, such as Grounded Theory (Glaser and

Strauss, 1967). Glaser and Strauss (1967) endeavoured to construct abstract theoretical explanations of social processes. Their qualitative inquiry moved into the realms of explanatory conceptual frameworks, thereby seeking conceptual understandings of the studied phenomena. I thought it might have been favourable for an enquiry into the use of hypnosis within integrative therapeutic practicing. However, I discarded it because my goal was to learn about the essence of my former clients' experiences, not to generate theory.

I also considered Case Studies Methodology (Loewenthal, 2007), where knowledge is developed from an in-depth analysis of a single case or multiple cases. This methodology was not selected on ethical grounds as I assumed my clients would not wish me to make public their case notes and materials such as writings, which have been produced during their therapy. Furthermore I also thought it would be difficult to get any research participants.

4.3 Pilot study

I carried out a pilot study to test the feasibility of a study focusing on my own psychotherapy clients. I sought to find out what the issues would be so I could resolve them before embarking on my main study. The main issues were regarding whether I could interview my own clients, and the potential validity and ethical issues that would emerge. I had found only two studies in which the researchers had done so: Etherington (2001) a phenomenological research on the experiences of two former clients and Jinks' (1999) study of clients' perceptions of change during long term counselling. Encouraged by this, I carried out an audio taped, semi-structured interview of my former client K.R. (assumed initial).

Prior to the interview I discussed with her the implications of taking part, including the positioning of me in the role of a researcher rather than therapist in order to keep a boundary between these roles.

The interview lasted 90 minutes. I noticed during the interview that the participant felt very comfortable in the consulting room and how much she wanted to reflect aloud about her therapeutic journey. I was also struck by how much she appeared to not be verbalising. K.R. appeared to be assuming that I already knew what her therapeutic issues, process and outcome had been. She therefore found little need to describe the details of her experience. The question that arose in my mind during the interview was: would K.R. be disclosing more details about her lived therapeutic experience if she thought the interviewer had no pre-knowledge of her experience? These observations influenced my analysis of the limitations of the knowledge that would emerge when a therapist interviews their own clients after therapy. The material that I gathered did not contain enough explicit information about K.R.'s therapeutic issues, process and outcome. It also struck me that, although she appeared to feel free to speak her mind, on occasion I thought she might have been trying to please me with her responses especially given the potential power imbalance between us.

The pilot interview raised concerns about the validity and trustworthiness of the data and the ethics of dual relationships. It raised many issues regarding the study design in which the therapist is the interviewer of her former clients. I decided to look for options available for learning from my clients that would potentially be less compromising of the validity and trustworthiness of the study.

I considered De Rivera's (1981) Conceptual Encounters methodology consisting of employing a co-researcher that would interview my former clients and then engage in a discussion on the co-researcher's sense of what the client's experience had been. This method was discarded as the main focus of this methodology is the interaction between researcher and co-researcher (De Rivera, 1981) and the focus of my study is primarily the lived therapeutic experiences of my former clients.

Finally, having considered all the above, I decided that I would employ an independent person to interview my former clients face to face. In addition, I decided that before the participants' interviews, I myself would be interviewed during which I would explore my experience of the participants' therapeutic experiences, within the framework of their therapeutic outcomes. The aim of this additional interview, the interview of me as therapist to the clients, was to compare and contrast the participants' and the therapist's experiences throughout the project and so allowing me to maintain in view my for-structures (assumptions and pre-conceptions).

4.4. Recruitment of participants

A letter was sent to all my former clients that I had treated with hypnosis during the years 2007 and 2008. These were 39 former clients. I invited them to take part in this research, explained the research aim and stated that if they were interested in participating they should contact me for further information. In the beginning of their therapy all of these clients had been informed that I was potentially interested in a long-term follow up for research and that I may consider asking them in the future, once the therapy had ended. I was particular interested

in learning if their therapeutic outcomes had been long lasting. They were told that declining to be kept in mind for research would not affect their treatment or their possibility of resuming therapy after therapy had ended. None of them declined to be held in mind for research. Before their therapy ended, the subject of research was mentioned again and all these clients gave me permission to be contacted for research purposes at some point in the future.

Of the 39 former clients that I invited to participate, seventeen contacted me offering to take part. Fifteen responded thanking me for the invitation and stating they would have liked to participate but that they were unable to do so. This was due to different reasons including having moved away from London, lacking time and having a new born baby. Seven clients did not respond. For this idiographic inquiry (Smith, 2008) I purposely selected 10 of the 17 clients that had contacted me offering to participate.

I thanked the seven clients that had offered to participate but were not taken on. I explained that I only needed ten participants. The participants' selection criterion was based upon obtaining a fairly homogenous group of participants for the purpose of IPA (Smith, 2008). This is a closely defined group of participants for whom the research question will be significant (Smith, 2008). The rejection of research participants is re-visited in the discussion section.

The inclusion criteria required the participants to be adults who had received the same type of therapeutic sessions consecutively for three months or more, and that the participants all had similar therapeutic aims: coming to therapy because they wanted to feel better within themselves and wanting to recover from anxiety-related problems. They were all trated by me under my integrative approach.

Furthermore, all the participants' treatments had included clinical hypnosis in every session. The weekly sessions lasted 90 minutes; consisting of 40 minutes talking therapy, followed by 40 minutes in the trance and 10 minutes reflecting on the experience. The exclusion criterion was based on excluding possible participants that would create a heterogeneous sample, incongruent with IPA. Therefore, I excluded clients that had received a different therapeutic session structure, clients that had come to therapy with additional presenting concerns such as substance dependency and diagnosed personality disorders, and clients that had had therapy for less than three months.

The participants were all Caucasian and English speaking; although for two of them English was not their mother tongue. Their ages ranged from 20 to 62 years with an average age of 36 years. There were three men and seven women: with American, Australian, British, South African and Lithuanian backgrounds. Table 2 shows the participants' demographic characteristics.

Table 2.

Demographic Characteristics of participants (N=10)

Characteristic	n
Gender	
Male	3
Female	7
Age	
25-30	3
31-35	3
36-45	3
46+	1
Education	
Bachelor's Degree	6
Vocational training	4
Socioeconomic Status	
Working Class	1
Middle Class	9
Race/ethnicity	
White	10
Partnership Status	
Single	4
In a relationship	4
Married	2
Nationality	
British	5
Eastern European	2
South African	1
USA	1
Australian	1
Mother tongue	
English	8
Hungarian	1
Lithuanian	1

The therapy duration ranged from six months to twenty four months. Eight participants had already had therapy for the same presenting issues before coming to therapy with me, and two had had no therapy in the past. Their presenting concerns were anxiety, depression, trauma, eating disorders, panic attacks and psychogenic migraines. Two of them had had hypnosis before and were dissatisfied with it. Table 3 shows the participants' therapy characteristics and uses assumed names to preserve confidentiality:

Table 3. Participants' therapy characteristics

	Length of therapy in months	Presenting problem	Previous therapy
Ken	6	severe migraine trauma	Neurologist psychiatric /CBT
Lucida	18	depression/anxiety	Counselling
Mandy	9	bulimia nervosa	CBT/counselling Hypnosis once
Willow	6	depression/anxiety	family therapy
George	12	eating disorder/anxiety	Counselling
Gabby	6	eating disorder/trauma	None
Alice	24	depression eating disorder	Couple therapy Hypnosis once
Kim	12	anxiety panic attacks	None
Gwen	8	anxiety relationship issues	Counselling
Chad	26	depression/anxiety	Long term (6 yrs) Psychodynamic

4.5. The interviewer

The interviewer was a UKCP registered therapist and fellow doctorate researcher. Her contract consisted of carrying out eleven interviews. These were ten interviews with participants and one with me as the therapist of the participants. The interviewer had no previous experience of hypnosis. Furthermore, in my view she held most of the traditional, negative misconceptions of hypnosis. I believe that the interviewer's critical views were a positive influence on the interviews, because as well as seeking the participants to give extensive details of how they went into trance and what went on for them, she also asked whether they ever felt

pushed in a direction that they did not want to go. She asked open questions such as what it was about trance that was different to talking therapy; and she also asked for detailed examples of their experiences and how they had impacted their lives. I found the interviewer's bias helpful in ensuring rich descriptions. They did not appear to affect the participants' views and expression of their experiences.

4.6. Procedure

Each research participant and I as the therapist to the participants were interviewed on a one to one basis by the independent Interviewer. The interviews lasted approximately 90 minutes and were tape recorded. They were conducted in my consulting room, where the clients' therapy had taken place. The Interviewer followed a broad Interview Guides (Appendices 2 & 3). The therapist's interview took place before the participants had been interviewed, and this interview was analysed before the participants were interviewed.

4.7. Interviews' analysis strategy

IPA was used to analyse the data that emerged from the interviews, as outlined by Smith (2008), Smith & Osborne (2008), Smith et al., (2009) and Saldana (2009). In order to carry out the analysis from the heart of my participants' therapeutic experiences as described in their phenomenological interviews to a set of master themes, I followed the IPA guidelines (Smith et al, 2009).

This involved four phases for each interview:

- Phase 1: reading and re-reading the transcript.
- Phase 2: recording initial notes.

- Phase 3: developing emergent themes.

-Phase 4 consolidate these emergent themes to form master theme.

Individual interview analysis

I followed an idiographic approach to analysis. Each interview was analysed individually focusing on repeating patterns, whilst staying open to new emerging themes (Smith & Osborn, 2008). I began by listening to the tape-recorded interview while reading the line numbered transcript. I then carried out a preliminary line by line scrutiny of general meaning extracting analysis. The descriptive and conceptual emerging meaning units were allocated into the transcript's right margin. These varied between single words and short sentences. At the end of this task the interviews were read again to upgrade the analysis via an interpretative dialogue with the text. The emerging themes were recorded onto the left margin (Appendix 4a). From the first transcript analysis over 155 themes emerged. These were reduced to 39.

For the next stage, I used a more analytical approach, to make sense of connections between emergent themes. I clustered the themes into families of themes grouping similar meaning units together. Smith & Osborn (2008) use the metaphor of a magnet to describe this process, with some of the themes' meaning pulling others towards them and facilitating sense-making. It became evident that there were similarities and differences between them. Once a theme was identified it was then sorted in terms of its specific properties and dimensions. Patterns were formed when groups of properties aligned themselves under various dimensions originating master themes. For example, the "dual therapeutic

process" clustered under the master theme, "the therapeutic process /the journey's felt sense". The "dual therapeutic process" depended on "experiencing therapy in the trance" and "experiencing therapy during talking therapy". For example, the master theme "experiencing therapy in the trance" encapsulated the meaning units of: "sensorial trance experience", "cognitive trance experience", "perceptual trance experience", "consciousness trance experience", all clustering under the theme "subjective experiences of trance". The themes were reduced to a few master themes for each interview.

Each master theme aimed to capture the essence of the meaning from the text in relation to the research question illustrated by using a representative quotation from the text. This procedure entailed regular checking of interpretations and themes within the transcripts (Appendix 4b). Key quotations from each interview were selected to represent each subtheme that generated a master theme and a table was produced (Appendix 4c). A careful tracking of quotations of emerging themes was kept at a case level as shown in Appendix 4d. To validate the coding process and the resulting master themes, the analysed interviews were presented to my research supervisor, the interviewer and to my peers or "critical colleagues" for validation checks.

Cross-case Analysis

Once the ten participants' transcripts had been analysed and a table of themes and quotations was produced for each transcript, I undertook a horizontal distilling process, whereby the master themes across all ten interviews were laid side by side. Following this process, composite master themes were developed. Five

master themes were distilled which emanated the essence of all the participants' lived therapeutic experiences within the framework of their therapeutic outcomes. Two tables were produced: Participants' master themes and subthemes (Table 4) and Participants' master themes quotations for the group (Table 5, Appendix 4d). These themes were then expanded into a narrative account, which is the basis in the Outcome analysis: Findings section of the Participants' experiences.

The Therapist interview's analysis, my generic interview as therapist to the participants was also analysed as the above described individual interview's analysis. The issues explored in this interview were my experience of the participants' experiences within the framework of their therapeutic process and outcomes. During the interview I focused on remembering their therapeutic experiences from my perspective. The Therapist interview's analysis distilled two master themes. These themes and sub-themes were expanded into a narrative that formed in Findings the Therapist's experiences section. The distilled essence of the participants' experiences was then compared with the therapist's experiences of the participants and a table of comparison was produced called: Comparison of the participants' and therapist's experiences (Table 6).

4.8. Validity and Trustworthiness

I tackled the issues of validity and trustworthiness in this phenomenological research from the premise that validity is based on the authenticity and trustworthiness of the manner in which the researcher approaches the interviews, and the reduction of the interview material (Smith et al., 2009). This study demonstrated issues of validity and trustworthiness by implementing a method for

authentication of the researcher's analysis through the following verification procedure:

1) A prolonged engagement with the descriptions and the "in dwelling" with the participants' experiences, reflected in detailed transparent documentation of the whole methodological procedure.

2) Involving the codes to be scrutinised by colleagues. This consisted of obtaining feedback from a pool of people who reviewed and commented on my coding. This included: two critical colleagues, who were asked to check the transcripts' analysis. They were both psychotherapists and Metanoia's fellow doctorate candidates undertaking qualitative research. It also included feedback from the interviewer, who was asked to randomly choose parts of each recorded interview listen to it and check the transcript. In addition, she was asked to randomly check all of my transcripts' coding analysis in detail. I also received feedback from my research supervisor; once the material has been coded into themes. I consider all of the feedback as parts of independent audits (Smith et al., 2009).

3) Using an ethical-mindedness that aimed to honour the true voices of the participating group by using their own words wherever possible in the writing up of the work.

4) Presenting sufficient evidence to illuminate and elucidate the phenomenon in an audited trail. An audit trail was kept documenting every aspect of the research. Verbatim quotes are used to illustrate themes.

5) A process of "member checks". All participants were offered a copy of the transcript. Two of them, Gwen and Lucida, asked for it. In addition, each participant was sent a copy of the findings and told which assumed name represented their quotes. Participants were invited to make comments, and reminded that they could withdraw any quote they felt uncomfortable with (Appendix 4). All participants replied by saying that they had enjoyed reading the findings. With the exception of one participant who wanted her pseudo name to be changed no other participant suggested changes. Part of this process involved the participants identifying anything important from their experience which had been left out of the findings. They all commented that they were satisfied and did not wish for any part or whole of their statements of their lived experiences to be removed from the findings; neither did they want to add anything.

I reflected that I could take this result at face value and believe that the participants felt accurately reflected in the findings. However, I could also interpret the opposite that, this response reflected the power relationship between me as the former therapist of the participants and thus it might have impacted the participants' checking procedure. I held the two opposite possibilities in mind. However considering how freely participants have expressed their experiences and views in during their interviews, I assumed that this influence would have been minimal.

6) Keeping a reflexive journal in order to monitor my own responses and interpretations of the interviews. A research journal was kept in addition to keeping the audio recordings and transcripts of the interviews. It contains the story of my research, its development and detailed factual tracking of events with

my reflections upon these occurrences. This also enabled me to consider my own presuppositions, which I discuss next.

4.9. Presuppositions

In addition to all the above, I aimed to attain trustworthiness in this study through epoché. Epoché involves the examination of my fore-structures: My assumptions and preconceptions. This is an essential process in phenomenology; the researcher must make an examination of presuppositions with regard to the phenomenon under investigation. In making explicit those beliefs, the researcher tries to come to terms with them, rather than ignore those (Moustakas, 1990) mitigating its negative influence in the data analysis.

From the examination of my fore-structure, certain beliefs became evident and these in fact helped me to maintain focus by anchoring the study and provided a framework alongside which the experiences of the participants and therapist could be placed. The epoché was developed from my experiences of my clients' therapeutic work as a therapist and as a recipient of therapy. This exercise underscored and suggested questions which should or should not be asked in my pilot interview.

I reflect about my position as an integrative therapist who values and uses clinical hypnosis. This experience spans over ten years, and includes some 1300 sessions given to many different people. During this time I have witnessed many sessions in which my clients have had a therapeutic breakthrough when working in the trance. Some of them have gained profound insight about different aspects of self

experiencing, deep conflict resolutions between ego states, the safe expression of dissociated affect, and the removal of symptoms in an almost miraculous way.
I acknowledged that I have to be profoundly attuned to my clients during trance work. I sense my clients as vulnerable and under my care during the trance work and I feel that we communicate in a similar way to a mother communicating to her young child. Consequently I have inner expectations that the participants should find me more emotionally attuned to them during the trance work.

Furthermore, I noted that I had experienced the benefits of hypnosis in my own life and it has impacted me in profoundly positive way. As I reflected on my experiences as a therapist and as a client, who was a recipient of trance work, the following additional thoughts and beliefs became evident:

1) Trance experiences are strong in imagery, profound in feelings and are long lasting.

2) Some experiences are pivotal and stand out from other trance experiences.

3) Trance experiences can be recalled and described.

4) The therapist may enhance the trance experience, or may interfere during the experience.

5) What can heal can also harm.

6) Prejudice against hypnosis is widely held and may be present in the clients and in the interviewer inter-influencing each other.

7) I valued working in the trance and I wanted to demystify clinical hypnosis.

Despite these beliefs, I attempted to retain an open mind; I made sure I was very aware of the possibility that some or all of the participants might have had very different experiences including irrelevant or negative experiences.

Kvale (1983) has pointed out that the examination of presuppositions does not imply an absence of presuppositions; but a consciousness of one's own presuppositions. I made sure I was critically aware of fore-structures whilst listening to the participant's recorded interviews, during the reading of the interviews' transcripts and throughout the analysis of the data. Furthermore, I examined my preconceived ideas and assumptions, from the perspectives of the therapist and the clients' co-created interactions. I acknowledged that as an insider researcher my participants and I could not be free of pre-understandings, particularly because of our former position of therapist/client. We had navigated together in therapeutic waters during a time in which important issues in the participants' life journey were explored.

I remain aware that I had knowledge of the participants from the time when they were my clients and they had knowledge of me when I was their therapist. This previous relationship had advantages and disadvantages. I acknowledged that it could both become a threat to the process of naturally evolving discovery and new knowledge. At the same time, it could also be an advantage as a source of rich material that produces information from the actual intervening parties engaged in real therapeutic encounters.

I addressed this issue in the study by adding a generic interview of me as the therapist to the participants about my perceptions and experiences of my former clients' experiences in therapy. I considered that this additional interview would place in the open my subjective views of my participants' experiences in a more tangible way. Consequently, it would overtly assist me to maintain a reflexive

stance on the dialectic tension between the researcher's material and the researched. My aim is towards increasing self-transparency following the ideas of Gadamer (1998) and focused my endeavour on the fusion of my horizon as a practitioner-researcher's belief and experiences and that of my participants.

4.10. Ethical issues

Ethical approval for this study was granted by the Research Ethics Committee of the Metanoia Institute (Appendix 1). In planning this piece of research the ethical implications of what was being undertaken were uppermost in my mind. As a member of the Metanoia Institute I abide by their Code of Ethics (Metanoia Institute, 2013). In addition, as a member of the British Psychological Society I adhere to their Ethical Principles and Code of Conduct (BPS, 2009), which includes guidelines for ethical conduct in research.

I was aware that the interviews evoked memories for the participants, and I needed to check that they had a support structure in place. Furthermore, that they understood that they could contact me for a further de-briefing if necessary. Part of the Interviewer's contract was to carry out a careful debriefing of participants at the end of each interview, and to pay particular attention to the participants' possible vulnerabilities. I describe later the measures taken to cater for the possible negative impact of the interview on the participants. I was aware that issues might have arisen from disclosures, which participants may not have felt comfortable about. I also checked that the participants understood that they could withdraw at any time before research completion.

The principles of informed consent, confidentiality and the intention to do no harm were my guide. Informed consent can be described as when the person is regarded as having the right to choose whether or not to participate in research, and therefore must be given the information necessary for this choice in a non-coercive manner. I provided a clear contract in which the participants were made fully aware of the objectives of my research and I thereby addressed the core ethical principle of *beneficence,* acting to enhance the participants' well-being. I hoped the interviewees benefited from the interview by using it as an opportunity to enhance their self- reflective capacity.

I ensured that the principle of beneficence was not compromised in the interests of my research. I am aware that many researchers restrict their moral responsibility to the principle of avoiding harm, but as a practitioner researcher with a responsibility towards my participants, I seek to go beyond non-maleficence in striving to enhance the well-being of my clients. I consider that self reflection increases self awareness, a crucial element in personal growth.

I also abide by the ethical principle of *non-maleficence* by attempting at all times not to cause harm to another individual. To achieve this I ensured that the Interviewer, as part of her contract, provided all of the participants with any necessary information to complete their understanding of the nature of the research by answering questions. The debriefing after the interview intended to monitor any unforeseen negative effects, such as a re-surfacing of difficult issues, or misconceptions (BPS, 2010).

I maintained the ethical principle of *fidelity,* treating everyone in a fair and just

manner, by describing the interview process using a standardised format. This included explaining the interview process and the length of time required for interviews. I also made clear the time commitment required.

I observed the confidentiality principle in the recording of interviews and the transcript material that was produced by using a pseudonym. I kept all the materials in a locked drawer and the material stored in a computer is encrypted. I also abided by the ethical principle of *autonomy*, respecting the right of the person to take responsibility for him or herself, and making it clear that the participants were free to withdraw at any time.

I considered that it was crucial to make apparent to the participants the difference between my role as a therapist and as a researcher. I was aware of a power imbalance issue in my role of participant researcher and that this role might influence or alter what was or was not disclosed during the interview process. I addressed it by not being around to be seen by the participants on the interview day and by employing an independent interviewer, who could adopt a genuinely respectful "curiosity' in the participants' experiences. I thus hoped that the participants would perceive the research and interviewer as honest, accepting and non judgmental.

The participants were former clients of mine, and I was aware that the interview process was in-depth. My concerns lay with the participants and how the interview would impact them and whether issues would be raised as a consequence. Therefore, I developed a plan of action should difficult memories or unresolved psychological issues arise as a result of participating in the research. I

was aware that "being in reflective relationships with my participants, the interview creates a level of intimacy that might invite them to reveal previously unarticulated, deeply personal stories" (Etherington, 2004: 226), or re-open doors that the participant thought had closed. To tackle this, the participants were carefully debriefed after the interview and asked how they had felt speaking about the issues. The BPS guidelines for research ethical conduct regarding de-briefing were followed by the interviewer. These state that before participants leave the research setting, they should be provided with any necessary information to complete their understanding of their experience and clarify any misconceptions or negative effects.

The participants were offered the choice of a free therapy session with myself or another therapist (paid for by me) if further work was required in order to process the interview. However, no one asked for it. Furthermore, in the invitation letter to participants, participants were given the address of the Metanoia Institute and the name of my research supervisor for them to write to, should they have any complaints against the researcher or the research procedure. In addition to the above, it was explained to participants that the study might be published, and that the anonymity and confidentiality principles would be abided by.

Participants were reminded to take responsibility for the disclosures at the beginning of the interview. However, although client identity was kept anonymous, it was necessary to discuss the possibility of clients recognising themselves in some descriptions. Therefore, participant checking was included not only to assess trustworthiness but also to allow participants to change details that made them potentially identifiable, although none of them did.

5. ANALYIS OUTCOME: FINDINGS

5.1 Participants' experiences

This section presents the results of the Interpretative Phenomenological Analysis of the ten participants' experiences of psychotherapy, followed by the results of my generic interview as the therapist to the participants.

My focus throughout this study informing my data analysis has been the participants' lived therapeutic experiences and the meaning of these experiences to them in relation to two dimensions: talking therapy and in a trance state. Data analysis led to development of five master themes and a series of sub-themes, as outline in table 4. Each master theme constituting a broad concept representing the essence of the participants lived experiences within realms of therapeutic experiencing.

In the narrative below in which I describe these themes, when I am discussing the two modes of therapy separately, I name them either "trance work" or "talking therapy work". Some of the participants also describe trance work as "focus work".

Table 4. Participants' master themes and sub-themes

1. The meaning of therapy THERAPY AS FREEDOM FROM A SHADOWY MAZE	The self in a hopeless place
	Trapped & out of control -vs.- Freer & in control
	A better way of being in the world
2. The therapeutic process THE JOURNEY'S FELT SENSE	Dual therapeutic process
	Meeting the shadows
	Surfing the waves
3. Therapy in the trance THE UNIQUENESS OF TRANCE WORK	Profound relaxation
	A pathway to the unknown-known
	The magic of the mind
4. The transformational process WHAT MADE THE DIFFERENCE?	Participants' theory of change
	Moving from dissociation to connectedness
	The commuting self: reflecting & experiencing
5. Relationship with the therapist THE GUIDE	A good relational space
	Someone is looking after you

First master theme

The meaning of therapy: therapy as freedom from a shadowy maze.

This experiential realm comprises themes related to what therapy meant to the participants within the context of their life journey. All participants described having experienced a movement that led to a positive shift in their psychological well being. It included an overall sense of a positive experience in both talking therapy and trance work. This is depicted as a movement from feeling stuck in

psychological distress prior to therapy, to a feeling of release from this distress by the end of the therapy. The sub-themes encapsulated in this master theme are:

- The self in a hopeless place.
- Trapped and out of control versus freer and in control.
- A better way of being in the world.

The self in a hopeless place

All the participants described coming to therapy as the last resort. They reported it as: "*I was close to suicide", "anxious, very anxious about everything", "very, very, very, very unhappy", "out of control", "I felt my mind was toxic", "depressed".* They all described feeling overwhelmed by their symptoms and unable to cope any longer. I was struck by how distressed the participants were before their therapy, as encapsulated by Willow:

> *Feeling very depressed very down on myself. I think that I felt like, I guess I felt like there were some aspects of myself that had brought me to that situation. You know. That I had like failed in some way and that's why nothing was going right. I just found it more and more difficult to just cope.*

Trapped and out of control versus freer and in control

Participants related that prior to therapy, and as a consequence of their chronic psychological distress, they had felt a sense of erosion in their capacity for doing things. Their lack of self-agency had been holding them back from living the life they wanted. They all described moving away from this limiting place because of the therapy and that this change meant an improved way of existing in the world. Kim's account illustrates what it meant to her to have moved away from her obsessive fear of death:

> *I'm pregnant now which I suppose is a huge one. Because I didn't think I'd ever. Because that was a fear that I had, is death and I couldn't ever think of being a mother... and now I'm expecting my first child!*

From Kim's words about her improvement, I conclude that her "*huge*" transformation was not only deep enough to move her away from her debilitating symptoms, but it also changed her quality of life, making it more fulfilling.

Participants reported feeling stuck, trapped in negative repetitive patterns of experiencing that they could not control. They experienced that the therapy released them from these feelings. Gabby's account describes this in relation to overcoming her eating disorder:

> *I was binging purging, taking laxatives. Now I do not do that anymore.*

She expanded*:*

> *Prior to that I had anorexia and then it's kind of stuff I never dealt with. It developed into another eating disorder... my weight was fluctuating about three times a year by about 10 kilos* [1.57473 Stone].

Kim and Gabby's excerpts illustrate what was expressed in all of the participants' interviews. They said that during their therapy they were able to move away from the problems that brought them to therapy and that their inner transformation improved the quality of their lives. This makes me think that the therapy has had a significant positive impact, going further than the removal of their symptoms. I reflect that it had been 24 to 27 months since their therapy had ended. The positive effects had lasted and pointed to a deeper transformation of the self.

A better way of being in the world

The participants' experiences of the overall impact of therapy within their life journey are encapsulated in this sub-theme by a sense of liberation and self-growth experience. The participants expressed it in phrases such as: *"a great sense of freedom now, I don't feel trapped*", "*learn to love myself", "freedom that wasn't in my mind that now is in my life*", "*really built up my self esteem and my feelings of self worth", "sense of relief, letting go", "a sense of wellbeing" and "realising my value".*

Participants experienced that their engagement in therapy not only removed the symptoms that were making them distressed, but also strengthened their sense of self. They did not use the phrase "sense of self". However, they reported that the therapy had a real impact on their self esteem and self worth, contributing towards a better way of being in the world. Chad's description below encapsulates it. He has faced a profound internal battle during his early teens to accept his sexuality. He was sixteen years old when he dared to have his first gay experience which resulted in Chad becoming HIV positive. This event changed his identity and the course of his life. He said that out of therapy:

> *Learn to love myself. Because there were so many downs, I have had so many doubts in my life about everything. This therapy has made me value myself, this trance made me look at myself with value. And to say I am entitled.*

As a result of trauma, I think that Chad lost all trust in his judgement of people and situations. He developed a reflective negative ego state that constantly devalued him (Kalsched, 1996) that out of therapy he has moved a long way towards the recovery of his self-worth.

The participants were all very distressed by their problems. Willow described the movement out of therapy from a dark place to a better place in a way that gives a sense of how it feels to experience this movement within the self polarities of being:

> *I think I have regained that optimism and I've regained that sort of fire in my drive, that joie de vivre that I had before everything happened that brought me to that really depressed state. But I have that. I have that same confidence and that same kind of excitement for life that I had before but on top of that I feel that I have the ability now to, if I start to feel bad or if I start to feel depressed again, I have the ability to take care of myself and not let it get me down in the way that it did before I came to therapy. I know how to kind of like protect myself and look after myself in a better way*.

I think that in her description Willow illustrates that the impact of her therapy went beyond a restoration of a former self to building a more resilient self.

Second master theme

The therapeutic process: The journeys felt sense

The second master theme comprises the sub-themes related to the participants' experiences of the therapeutic process itself. Participants described common therapeutic tasks in the two dimension of therapy (talking therapy and trance work). The significance of these tasks seems to vary depending on the different task's usefulness in deepening their inner processes. This master theme encapsulated the following sub-themes:

- The dual therapeutic process.
- Meeting the shadows.
- Surfing the waves.

The dual therapeutic process

The therapeutic processes "talking therapy" and "trance work" were experienced differently by the participants. Participants described these differences in terms of the therapeutic tasks carried out. Talking therapy was experienced as, "*the place to tell my story*", "*open your heart*", "*reflect*", "*download*", "*identify issues*". They described feeling accepted and safe enough to go into self disclosure. I think they used talking therapy as a place where trust was built. Hence, allowing open reflection and self disclosure to unfold. As Kim put it:

> *You are here in an environment where you can discuss how you feel about them. You think that you're crazy or, you know, your way of thinking is a bit weird or whatever but just a safe haven for you to just say what you want to say and how you feel about a situation and then processing it from there.*

Participants described the trance state as a state of: *"extreme focus", "complete calmness", "a deep relaxation, a lot of deep soul searching", "felt completely open and receptive*", "*a dropping in the mind to the bottom of a mind shaft", "in control", "enabling to tap deeper*". I think that these descriptions indicate that the participants experienced being in the trance as a state similar to either that of deep "focus meditation" or "mindfulness meditations". All of the participants described having both these types of experiences. Trance work was perceived by participants as a place to vividly "*visualise*", *"experience", "work through", "feel feelings"* and "*rehearse*" different ways of being. They described doing this using guided imagery via hypnotic phenomena.

All participants used hypnotic phenomena, although there were marked differences between the ways they described their level of consciousness during the trance. Some participants experienced a deep altered state of consciousness as

expressed by Mandy, Gabby, George and Ken. George described it as:

> *It's just something internal ... the mind to just, to switch off and, um, but it's switched off, but it's switched on at the same time so there's alertness within this total relaxation. I'm totally focused.*

And others feel that nothing different was really happening. Lucida, Kim and Chad felt conscious, in Kim's words:

> *No, it was the same, yes it felt like as if you were just lying there with your eyes closed, you could still function like normal…but that you wouldn't be listening or thinking about anything other than what she was actually saying.*

While Alice, Gwen and Willow reported experiencing different levels of alteration in consciousness depending on the sessions and their moods. Gwen describes it as a form of lucid sleep.

> *It is a conscious light sleep, I would say, working on the issues, um you are sort of guided by Yolanda to different places um, as I say she always, the imagery is always your own, um she does not put ideas into you head.*

All the participants said that in the trance they felt a sense of freedom to explore their inner self in a very private way. As expressed by Gwen:

> *I find it difficult to talk to things that are not there, sort of like Gestalt therapy in like talking to a chair. It is like I find that really difficult. Really difficult it is not my thing at all. But in the trance I would say sorry to myself, I would talk to myself as a teenager. I mean all of this would be featured in, then Yolanda would say what does she look like, she would never say she looks like so, and so, she would never put that, or any image into your head, the images are all yours.*

It appeared that participants experienced trance as an easy channel for self-to-self communication, guided by the therapist.

Regarding the session's structure, half of the participants' experienced that trance work was the core work and talking therapy was *"mostly a preparation for trance work" or just a "chat"* about the problem. In Ken's words:

> *The first part is more like psychological therapy when we work to get everything off my chest. Then we talk about the possible causes of the problem that I had and what caused it so it was more of a chat. Whilst going into a trance, it's just a whole different thing, it's a deep relaxation um a lot of deep soul searching, which I would not normally do if I weren't in the trance.*

The other half of the participants found that trance work and talking therapy complemented each other and could not be separated. In Lucida's words:

> I believe the two things [talking therapy & trance] work so well together. I would miss one if I didn't have it. It adds another dimension to therapy.

Participants found trance work helpful that in every session the issues brought to it were explored thoroughly. As Gwen put it:

> *Nothing was ever left half done, do you know what I mean. There was a sort of an actual conclusion. Um, to finish. Which often makes me think how long you know, was your times slotted … I've usually had an hour and a half appointment.*

Apart from Gwen none of the participants commented on the fact that the session lasted ninety minutes, although eight of them had had therapy in the past and could compare therapies. I think that this suggests that the length of the sessions was not an issue for the participants. What they sought was a fruitful working session. Half of the participants' experinced that a different amount of time was allocated to talking therapy and trance work, although in actual fact they both lasted the same length of time. They commented in the interviews that

"*little time seems to have passed*" during trance work. Time distortion is a well documented hypnotic phenomenon.

Meeting the shadows

This sub-theme encompasses participants' experiences when accessing and working through experientially - in the trance - the shadows behind their distress, shadows that were related mostly to early relational trauma. The experiences had been intense in accessing feelings of the past, and productive in discharging their energy and affect. Mandy illustrates this below. How during the trance she tackled negative feelings towards her father. She described coming to a session bringing anxiety about her compulsive need to please her boss at work. This was distressing to her, as she was constantly acting against her best interest. Once in the trance Mandy focused on this feeling in her body: wanting to please. This led her to a familiar scene, when she was aged six years old and had failed to please Dad. Dad was cruel to her. As a result she became aware of what her mind and body wanted to do there and then. She said, "I want to push him, push him away". She was therefore directed via guided imagery to do so at the point of rage:

> *She [the therapist] says imagine yourself, pushing those feelings of anger and frustration and resentment off a cliff. It's almost like letting go of them. And then also like pushing that person, like that side of my Dad that I hate, off a cliff and only reconciling with that person that I do get along with now… and that does makes me feel much calmer. It's just trying to break those ties... at the point of the rage pushing him. It gives me a sense of um it's almost like relief. I feel like something like a burden is gone from me in a way um, like I don't feel that need to desperately please this person.*

I construed that Mandy had developed an inner critical cruel reflective ego state that she need to please by pleasing authority figures. She also developed an

emotional dissociated fearful "Little Mandy" ego state that was internally punished when she was perceived as not pleasing enough, and at the same time was holding fear and rage towards Dad.

I think that the therapy work relieved the ego state of "Little Mandy" of the affective load that she carried out of Dad's way of relating. Furthermore, I understand that she must have safely bypassed defences since core affect has been released leading to a feeling of "unburdened". I think that these experiences took place while she was within positive, emotionally attuned therapeutic relationship that she might have felt safe and supported. Mandy reflected:

> *He [Dad] just wanted to perfect me constantly. Whereas I didn't realise that before I had the trance you know. Because you never understand why somebody would treat a child like that...the trance just helped me focus on that and get rid of the negativity... And so I can focus on the good things.*

Mandy expressed connecting in the trance how the experiences related to her inner need to please Dad were affecting her relationships in the present:

> *Pleasing him [Dad] that was always the biggest problem for me. I would apply it to everything, to all my relationships, with my bosses, my work colleagues. They were re-enactments of my life with my Dad.*

Mandy said that out of therapy:

> *I don't feel desperate to please everyone all the time, I just feel more content with my life since.*

I comprehend Mandy's reported shift that perhaps she did not need any more to compulsively enact the experiences that had been wounding to her, because the intrapsychic tension fuelling her "pleasing" mental actions to placate Dad's cruelty had been dealt with during her trance work. Mandy explained how she experienced working through in the trance:

> *It's almost like reliving the experience again. Um, and then exerting your own sense of control over it by breaking it. So um, I kind of retrospectively breaking the control. Strange.*

I think that Mandy felt unburdened and calmed after her experiential and reflective trance work, because she has perhaps integrated a sense of control in Little Mandy's ego state that contained her Emotional Part (EP) (Van der Hart et al., 2006). I think that maybe, her EP has been validated and allowed to release the affect (rage) dissociated in order to cope with Dad's cruelty when young.

Mandy expressed she has tracked and processed experiences and affects from the present sensations and feelings in her body. Participants experienced it as healing. Willow recalled:

> *I was in the focused state, where we did work on some particularly emotionally difficult issues. And we, she [therapist] would explore with me where if I felt it in any particular part of my body. And during those times I would feel, I would be able to kind of identify where I held that sort of tensions.*

Participants described engaging in focusing tracking and working through these current somatic sensations and in integrating it. Gwen explained:

> *It would literally get stuck right here [throat] and I would get throat rashes and all sorts of things happening in my throat… I could never get out what I wanted to say. If somebody had annoyed me, or in some relationship if somebody did something, I did not like or not being fair I would just sulk or sort of take it internally um, self harm myself.*

She expanded:

> *It did get stuck here [throat] and we sort of worked on that and desensitized that and I just sort of explored the feeling [in the trance] of where that was from and by the third session it was not there anymore. So that is great!*

Participants experienced that the work of connecting self-parts, such as inner

child, teenager, body and body parts, in the trance was particularly helpful. Gabby described:

> *So there is no longer the anger towards myself. I think so definitely. When we integrated the teenager self with the grown up me, I think we made a friendship and I think I feel much more grounded. And um. Grown into, into a person.*

George had a difficult childhood related to his father's abuse and severe bullying at school. Mum was supporting and loving, but she worked night shifts and was mostly absent. He said:

> *I would be in the trance and I would be able to speak to my inner child and say things and then I would be able to move myself, float literally. I would be instructed to float up and out of my adult body and down inside into my inner child and then to experience the feelings and the sensations of what it was like to be the inner child at that age and at that stage of my life. So I could touch into my fears and my anxieties.*

He expanded:

> *The language I would use would be very different, say a younger child or adolescent part of me, so I remember speaking from different parts of myself in a very different way.*

Participants' experiences seem to suggest that they have accessed segregated self states, worked through, and reconnected with them. Out of my analytical dialogue with their described therapeutic experiences I concluded that these trance experiences seem to have contributed towards achieving a validation and reconnection between previously disowned self states, releasing intrapsychic tension and fostering a more peaceful inner world. This appears to have generated a rebuilding of their sense of self, as expressed by Willow:

> *I think, it is like rebuilding a part of me that had fallen apart, that had deteriorated. Yeah, I would say that's what working in the trance felt like, it was like kind of putting the pieces back together.*

Participants' experienced that the therapy helped them to move away from unhelpful relational and behavioural patterns. These intra and inter relational patterns, I believe had developed during their life journey as creative adjustments to cope and were before therapy limiting their life choices. Moving away from pattern repetition was a great relief as Mandy said:

> *Is this sense of relief of what it feels like um like a sense of letting go, and it's really um this very powerful feeling. Um it's like; it's hard to hang on to your hang ups. When you try and break them in every session, so yeah relief I guess. I can't think of any force like that. I'm not really a mystical person.*

Participants experienced being able to express deeply held affects from the past in a safe manner. They explained that it was calming for them. George revealed:

> *I could feel the fear, I could feel my apprehension, my concerns and, I mean physically I would be lying here and sometimes I'd curl up, sometimes I would just clench up, um, screw my face up. Um, and it was again, it was again at that point, it was Yolanda's ability to, um, accept me as an inner child. To make that inner child feel relaxed and calm and again it was not any particularly specific words but it was a case of her [therapist] dialogue with the inner child, so there would be dialogue from her asking questions but it would be a case of, um, building rapport. I suppose you know, building rapport with this inner child.*

These occurrences were experienced differently by the participants. I reflect that during these moments, the participants might have carried out intense intrapsychic work, while they felt held by the emotionally attuned therapist. I think that at the same time the therapist was the eyewitness of experiences that perhaps were never acknowledged. I hypothesize that these person to person moments of meeting underscored the relational, the attachment aspect of trance work, when trance is a field of 'I-thou' organisation, and offers an opportunity for deep intersubjective relatedness.

I think that during these co-created dyadic states of consciousness and connection healing might have occurred. Furthermore, I theorize that perhaps these shared estates of affective resonance between therapist and participant, therapist and participant's dissociated self states and participants and self state, can not only act as an opportunity for new encoding of positive attachment relationship (Schore, 1994), but also perhaps contribute to a re-alignment of the participants' internal matrix of attachment relationships. As a result harmonising their subjective-reflective dyad's capacity for internal reciprocal attunement and resonance, and contributing to a more stable intrapsychic world. Participants' experienced that this better intrapsychic harmony could have had a positive impact on their other domains of self relating, such as the self to other relating and self to body relating. As George put it:

> *Now looking at myself as an adult, you know my feelings and experiences of my body, um, have totally changed my anxieties about my body image. My feelings of self esteem, self worth and my ability to be sexual and to be intimate have very much changed. And I think that has a lot to do with being able to have this dialogue, [dialogue with his inner child: self to self dialogue and therapist to child], acceptance and this psychical connection within the trance has, I think that really, really helped.*

From these descriptions I hypothesize that the work impacted the whole of their self organization.

Surfing the waves

Participants appeared to have experienced a process of learning to modulate affect. They provided rich descriptions of the way in which they worked through this in the trance via guided imagery. This work was perceived as

enabling participants to access affect and find ways of soothing themselves and of dealing with emotions which had previously seemed overwhelming. George described his experience:

> *I could have the experience that I was drowning in them [emotions] like in water. And then there's panic and there's anxiety. And then the experience of something new which was to understand that emotions rise up and instead of seeing myself drowning, I could see a more positive experience. Like I was, swimming or surfing... suddenly there was this knowledge and confidence that, the emotion would go away that it would subside.*

In the case of Kim, her fear of death had made her almost dysfunctional. Kim's life journey did not start well. Immediately after her birth, her father tried to pay a poor woman in the hospital to exchange babies. He had wanted a boy. She left home at sixteen years old; she could not take her Dad's abuse anymore and her mum had been too depressed to protect her. She described that learning to manage fear was a central part of her healing process:

> *The most important work that you did in the trance?*
> *Feel fear and then working your way to get to the other side.*

While in the trance, Kim experienced herself becoming fully aware of her feelings as they were was in the present. She described how she had felt and observed these embodied intense feelings reaching a peak, and how she stayed there and learned to go back from there, self soothingly. She said:

> *I remember her [therapist] making me trying to feel the feelings of extreme fear [in the trance] ...and then going to kind of a peak by working backwards from there. Um, in a self-soothing kind of way, teach myself how to, you know, soothe myself.*

All the participants described carrying out a range of similar exercises that were aimed at learning to modulate affect. They expressed in their interviews that the work felt safe. In Kim's words:

> *It's a safe place, where you can let your guard down, you know. And somebody's looking after you.*

I comprehend that the participants were able to do this intense experiential work towards developing their capacity to self regulate emotions via a shared states of affective resonance with their therapist in a relational space that felt safe. Kim expanded:

> *It just felt like a safe environment, I instinctively felt comfortable with Yolanda. And um, in that sense I think we could progress probably a lot faster into... sort of, the help that I needed. Because, I felt comfortable, relaxed and safe with her.*

Kim described feeling the presence of a caring therapist, "*connected all the time",* "*she's just like a comfort blanket*". I interpreted that it felt safe for Kim to carry out this work because she was having reiterative experiences of emotional attunement, and there was an intersubjective connection between Kim and her therapist encouraging her to carry out intense mindfulness based exercises.

Kim described not noticing much difference in her level of consciousness whether in a trance or wakefulness state. However, in the trance she carried out intense vivid, embodied experiential work, described as "*playing scenarios*". She said:

> *Let's say like I had a fearful time. And then working your way through to a more pleasant, do you know, place. So moving from a really horrible unpleasant like that. Not like a fear of movie scenario but that's a really dark place that you are in. And in working your way through your anxiety and fear... to a more colourful, brighter, happier place.*

All participants reported similar work. Kim was able to visualise vividly the sequence of feelings, sensations related to her fear of death. In each session she practiced ways of soothing herself. I make sense of it in terms of that she was expanding her threshold of affect tolerance. She also experienced processing these experiences during talking therapy:

> *I really needed to explain how I felt in order to process it. And then deal with it.*

Like Kim the participants said that they had difficulties in regulating their affect: *"I was overwhelmed by my feelings before the therapy", "I had panic attacks", "I could not control my feelings", "I had panting rage", "I had overwhelming anxiety", "I felt anxious, anxious all the time", "I wasn't allowing myself to enjoy things because something might happen", "fear was a huge obstacle"* and then they explained that out of the therapy this changed, they learnt to modulate affects expressed as: *"I found a middle ground about feelings", "I am in control of my feelings", "I do not panic any more", "I got rid of all of the anger", " I am not overwhelmed by feelings any more*".

Kim explained that learning to regulate affect was experienced as a gradual process:

> *Well you don't notice the changes or the achievement straight away, do you know. It's how then you move on and deal with your everyday life. And then like all of a sudden go, "oh" you know, I handled that differently. I've come out of it not being like, not having, you know, heart palpitations and racing heart. And you think oh wow! You know, that's when you get the clarity on what you've done before.*

I assess these reported experiences that, as a result of the therapy, participants had advanced their internal capacity for affect tolerance, feeling more able to

take risks. For example, after her therapy Kim went on a long trip to East Asia with her husband and on her return she decided to have a baby. She came to her interview the week before her baby was due. She explained in her interview that she would have never contemplated doing these things before, although she really wanted to do them, because of her dysfunctional terror of death. Kim has moved on a long way. In her words: *"It's a great sense of freedom now I don't feel trapped".*

She reflected on what this change meant to her:

> *I think I view myself now more of, more of an adult and I'm allowed to make adult decisions, and like I'm not that fearful child anymore.*

She expanded:

> *How I felt this experience was, it's like if you, your whole life you've carried baggage of anxiety, and whatever it is it's your problem. All you do is just you keep going down this one-way road... You know, there has to be an end to this extreme weight that you're carrying. All of a sudden you can go, well I can go around it now or I can get over it.*

The participants experienced a range of techniques while in the trance, to process the affect and integrate experiences. Only two participants mentioned a technique in the interviews, Gwen said: *"I can't remember what it is called".* I reflect that this omission was the result of the therapy's focus being fully on personal experiencing and not on techniques.

Third master theme:

Therapy in the trance/the uniqueness of trance work

This theme encompasses the participants' accounts of experiencing therapy in the

trance state. The participants' themes clustered under three sub-themes:

- Profound relaxation.

- A pathway to the unknown known.

- The magic of the mind.

Profound relaxation

All participants experienced trance as a state linked to profound mind and body relaxation. George describes:

> *You can feel your shoulders drop, you can feel your hands uncurl, you can feel you know your feet just, you know the ankle just relaxes and it's just like you're, you're like a piece of cloth over the couch. My body relaxes and releases physically that stuff in my mind where I could just feel as if I'm just going to a deeper place in my mind.*

This is a part of the trance induction procedure. The participants were asked to focus their attention and to breathe in a particular way, which is conducive to relaxation, a known feature of the trance state as encapsulated by George:

> *It's not superficial relaxation. It's a deep, deep, deep one. I feel my body really, really let go… having the body and the mind relax at the same time which is really unique.*

They reported that this state of calmness was deepened after learning to relax fully when thinking of a word such as the word "now". I understand it as classical conditioning. The participants use this learning as a resource, when not in the sessions and needing to calm themselves. George described it:

> *It's that anticipation, it's almost like padlock on the dogs, you know, you can hear the bell and then you know what's going to happen. I found that when I exhale at the point when she says "now" it's just like everything just goes.*

Participants reported that being calmed in the trance made them more receptive to

exploring a deeper level of experience, triggering an inner search for personal meaning. In Ken's words:

> *Deep relaxation allows me to explore a deeper level of experience. It allows you to, in detail, to look at your experience vividly. Was like profound relaxation, soul searching at a deeper level.*

Participants were impressed by the calming and relaxing effect of trance. I think that the relaxing qualities of the trance state appeared to free their psychic energy and direct their focus attention away from their state of constant hyper vigilance. Ken said:

> *I'm at three levels of communication outside this room [consulting room] completely shut, inside this room, um, certain level of awkwardness and then in the trance complete, um, completely open and receptive.*

Ken expanded:

> *Yes the deep relaxation allows me to explore a deeper, deeper level of experiencing, in detail to look at your experiences. And I am convinced that you couldn't so vividly experience that outside of the trance.*

I believe that the relaxation facilitated a shift of attention to an inner focus of awareness that they directed towards a search for personal meaning.

I think that the participants' felt encouraged to go further by this *"unusually comfortable experience"*. I interpret that it was as if the constant hyper-vigilance and hyper-arousal symptomatic of post traumatic stress were temporarily suspended while in the trance, because their nervous systems had moved into a calm mode. As Kim put it:

> *Complete calmness which is not something that I had experienced, because I've been dealing with quite a bit of anxiety.*

A pathway to the unknown known

This theme arose from the rich descriptions of participants gave of having accessed subconscious memories and processes, and of having processed and integrated these experiences while in the trance. They described the latitude of trance working as: "*go further", "it does go deeper", "unlocks a little door","gets to the core"*. They described gaining access to what had been out of awareness in the present but buried in their mind in a healing way, as illustrated by Gwen:

> *It really tapped into that deep um subconscious. And you're aware of what you're saying and things come to light that I never thought about or had obviously thought about but I buried it. And it's come out in that. So I've had quite a few sort of like ah! Moments.*

The participants' words *"deeper*" and "*profound*" are repeated in all the interviews as adjectives describing the therapeutic potential of trance work. I infer from the interviews that they accessed what I interpret as their "semiconscious material" the "unthought-known" (Bollas, 1991), in a way that was insightful and facilitative to inner reflections. This access occurred via guided imagery or spontaneously. These experiences were expressed as positive facilitating focusing on the crux of the problems. Illustrated by Mandy:

> *We spent a lot of time working on my relationship with my Dad in the trance. Which is something I would have never imagined was the reason why I wanted to make myself sick after I eat.*

Gabby described that she accessed the root of the anger that pervaded her existence.

Definitely anger, definitely the anger issues we sorted and once I'd taken the anger out, so many things came into places.

Gabby described that in the trance she was able to access her anger and expel it from her mind and body.

She remembered:

I remember the first session with the anger when we dealt with that. It was very exhausting, very exhausting. But as I said we used that metaphor of a sieve everything, evaporated out of my pores... and then eventually in the end with the images of "let it all out", "let it all out," it was coming all out.

She reflected:

Anger was coming from my past and it has been the guilt of not showing my emotions to my Mum.

Her Mum had been the victim of severe abuse from her Dad. In my view, Gabby had developed an abusive ego state identified with her Dad, that it internally abused her emotional part (EP) (Van der Hart et.al, 2006) - the part that felt for her Mum. She faced an internal "stay away-versus- come close" conflict that prevented her from supporting Mum. The anger towards her Dad has been re-directed towards the self as self hatred. Gabby describe in her account that in the trance she experienced reverting this process.

Participants described having similar experiences to Mandy and Gabby. It seemed that the trance work facilitated access into self material and working through some core underlying dynamic behind their psychological distress.

In Gwen's case, one of her issues was her position in the family, the sense she carried of always being inferior to her brother. It affected her sense of self-worth and her ability to relate to others. This led her to devalue herself and to be devalued by others:

> The first time I was told I wasn't good enough, which was really, you know, that was quite a revelation *as well. And that was when my brother, sort of at the age of 5, going to school for the first day. Um, and I was 3 and I said I wanted to go and he said "you're not good enough". And that just really stuck. It was like, God! You know where's that, where I've drawn that from? But I can see it, I can visualise [in the trance] the living room as it was, so it's really, it's like playing an old movie in your head.*

Participants appeared to be able to access memories and feeling via different hypnotic phenomena, for example spontaneous regression in Gwen's description above. At other times access occurred via guided imagery such as described by Gwen when working with affect from her past:

> *I launched my Mum into space and my brother as well. I took my brother out right at the last minute because, as I said, it's not his fault.*

They also seemed to experience access to embodied experiences in response to a broad question posed by the therapist. This created spontaneous shapes, images, words or symbols that triggered the participants to work in a way similar to the psychoanalytical method of free association. This is illustrated by Chad:

> *She asked me [therapist] questions in relation to myself or parts of myself and I would go with what immediately came into my head that really came into my head, to describe that immediately. So I would come up with something. I don't know if spontaneously, the right word is. I think that it was something incredible real. That came into my head that I actually really felt. Because it came right there and right then, click, click [he clicks his fingers fast twice] and I didn't need to think about it.*

He expanded:

> *[Trance] Start from scratch and an image is then formed, is like a blank canvass where you start from zilch and you create something from the inner truth of yourself from where you are deeply feeling.*

This type of trance experience could be interpreted as Chad accessing parts of his nurturing true inner self. Likewise Lucida talked about visions that she saw of herself that were not herself from which she gathered strength.

It seemed that trance work was effective in enabling participants to access their subconscious memories of past events and feelings. Alice said in her interview: *"You find what you really feel not what you think you feel."* The participants described a range of different experiences. I believe that that they did so because they were accessing and working with different kind of subconscious material. For example participants reported experiencing a self-nurturing at a deeper level. A kind of subconscious reparative work that I think might have contributed to mending a lack of certain self building experiences when young. In George's words:

> *There would be a reinforcement of my self-worth. You know again, at a very deep level there was this, unconscious connection. It was like an imprinting of, you know, "I am a good person". I mean all these wonderful words that as a child or as a younger person I never heard.*

I consider that perhaps the participants have lived through experiences in childhood that never evoked the required validating response from caregivers. I theorised that perhaps this lack of validation contributed to the development of their presenting problems, such us George's insatiable hunger and Alice's deep

sadness. They reported that the work was healing. I believe it might have been reparative at a deeper level, in undoing painful inner aloneness and rebuilding their sense of self.

Furthermore, it seemed that participants experienced easing psychological suffering by altering deep inner memories. I consider that this occurred when they had given self permission to allow hypnotic phenomena to create healing memories in order to overcome psychological pain. For example, Lucida suggested she has created a healing memory of her Mum responding to her in a positive way on her death bed:

> *Very healing! In fact incredibly healing. She responded in the way that I would have wanted her to respond. This wasn't the way she might have responded in reality. It was very real.*

This was experienced in many different ways. For example, Ken was able to experience support and love from his mum after an assault when he was a young teenager boy. This is not what had actually happened. For in reality, his mum was asleep and depressed and he was never able to tell her. Gabby was able to hug her mum and tell her how much she loved her and her mum responded in a very loving way. In reality, before her therapy, Gabby had not been able to do this as described in her interview.

The magic of the mind: hypnotic phenomena

Participants expressed working effectively through their inner issues via hypnotic phenomena. There was no fixed structure of how or what particular hypnotic phenomena was used. They described using a range of hypnotic phenomena

during trance work, such as hallucinations, regressions and time travelling often using a combination of these phenomena during a single session as encapsulated by George:

> *I could visualise this, myself in the future, being this different person. The person I wanted to be, the person that, um, that didn't have maybe the inhibition that I was experiencing in the now. And what was wonderful about these experiences is a very strong, again, visual representation. And of course I would float up be in that person and I could feel the difference. I could feel the strength and the power. Um, I could feel the confidence; I could feel, um, the clarity, the knowledge, the intellect and then the connection. You could feel this identity, this image and all the things it meant to you suddenly become part of you.*

Participants reported that during their experiencing of hypnotic phenomena they used a range of different sensory modalities, which felt like an integral body and mind experience. Above, George described rehearsing a new way of being and learning by watching himself in the future.

Participants' experienced that in the first session a hallucinated resource was created, a safe place that they used in the therapy and outside it. This skill was helpful to Ken as he could use it instantly whenever he had a sense that a migraine headache might be coming, he explains:

> *When something [migraine] gets triggered, I can get back to that exercise. So I only remember the trance when something triggers that exercise.*
> *And you relive that experience?*
> *Exactly.*

Ken expanded:

> *When do you feel a migraine coming up?*
> *I feel one coming up every three month or more*
> *In comparison?*

> *In comparison to having one every week, every week! That is a huge difference...."*
> *Yes, yes. I was close to suicide*.

I think that he learned to manage his chronic migraine headaches by learning to spot when a migraine was about to come in and prevented it from developing by changing his mental state. He was not always successful but he was able to reduce the frequency of the migraine attacks enough to improve his quality of life.

Participants described that the guided imagery used was nondirective of the place or content of the place, so they created something meaningful and personal. George illustrated it:

> *You can hear the water just dribbling down through the stream. And I can hear the wind blowing through the branches... It is my place of beauty and safety. I used to look forward to going in there*.

Participants provided rich descriptions to illustrate that after creating their safe place they used a combination of hypnotic phenomena to carry out experiential work related to their therapeutic issues. For example, George, who had unfinished business regarding the acceptance of his child-ego state, would spontaneously access experientially his inner child as a vision with embodied affect. In George's words:

> *There was a physical sensation. So when I float up and I move into the inner child it's not just the stuff in the mind but I could feel my body tensing up as I was back in that place again.*

Then with guided imagery his adult ego state had a dialogue with his child ego state:

> Y*ou've floated up into the inner child and you're then with your eyes closed, you're speaking and when you start speaking in that place, um, it's again, it's a very different experience. It's not from a conscious place. It's from a, I don't know a deep, deep unconscious place. Um, and again there is no inhibition. There's no feeling of judgement, because maybe you're feeling safe within the experience, you know. This young part of you has the ability to freely say you know: "I'm scared" or you know, "when you do this or when someone does this I feel like that". To be able to experience and verbalise feelings, emotions, fears and to feel that they are heard was a big thing. Because then I would float back into the adult. And it would be the acknowledgement and the listening and the support and to be able to reassure the younger part of me that it would be OK, that things are different now. I remember quite often to cement this dialogue or this learning and this understanding… there would be a hug.*

I think, that for George, it was as if it was happening in the present with the embodied affect of the child from the past meeting his adult self. His adult self was attuning to his previously disowned self state (child). I theorized that this deep genuine emotional involvement between George and his inner child "cures". This is because it has been precisely George's segregations (dissociation) of his needs as a child for recognition, acceptance and protection that has generated a child's ego state fearful longing for connection. At the same time it has generated a permanent affective avoidance. I think that George was able to do this work because he felt safe held by the emotionally attuned therapists.

All participants described visiting times in childhood to enquire what went on there and then; they sought insight about their current affect from their affect in the past and worked through it in the trance. George described:

> *It would be a safe place and there would be, my inner child would come along. And there would be I suppose communication. There would be dialogue between the adult, the adult self and then the child. And this ability to have this conversation, and what was great was, um, Yolanda, you know, helped me to move myself. That I could speak and experience and I would be in the trance and I would be able to speak to my inner*

child and say things and then I would be able to move myself, float literally. I would be instructed to float up and out of my adult body and down inside into my inner child and then to experience the feelings and the sensations of what it was like to be the inner child at that age and at that stage of my life. So I could, maybe touch into my fears or my anxieties or my thoughts at the time.

This work seemed helpful in reconnecting with dissociated self states and generating a more balanced inner world. Participants expressed that the work felt safe. They described how it felt when visiting a time in the past.

This is encapsulated by Alice:

In that space in the past…, you do feel quite held in that space. To be able to enquire into what was going on and the feelings it was throwing up, or you know what, what was going on, um, you are held in a, but like I said at the same time held in a, with a, a safety net of knowing that you're, you're not actually there.

All participants experienced that the usage of vivid imagery was key in trance work. As George said:

"Using the imagery which is so important, so strong".

For example in working through issues using guided imagery, Mandy described:

Things that happened that I am re-enacting or it's Yolanda trying to make me look at things in a different manner by, um, trying to make me let go of those physical feelings with my Dad. By having me in a room with him for example in my head and that's not reality obviously but imagine myself now as an adult and also myself as a child and then trying to break those feelings of insecurity and perfectionism and the need to please. Imagine yourself pushing those feelings of anger and frustration and resentment off a cliff. It's almost like letting go of them and then also like pushing that person like that side of my dad that I hate off a cliff. And only reconciling with that person that I do get along with now …and who I have a great relationship with and that does, makes me feel much calmer. It's just trying to break those ties.

The participants also reported that sometimes the content of these scenarios was suggested by the therapist and sometimes it was generated spontaneously by them and then guided by the therapist so they could generate their own imagery. Sometimes they described a combination of both. It depended on how the session was flowing. For example, when suggested to Lucida that she might perhaps consider going to visit an experience that she felt she needed to resolve, she spontaneously hallucinated sitting by her mother's death bed. She described this dialogue as "*incredibly healing*" because her mother responded the way she needed in order to achieve closure to her delayed bereavement process. This was also Ken's experience. He said:

> *My mother died quite... a few years ago. And I always, I found it hard to think of her, I always found hard to think of her because it meant an outlet of emotions. I just could not imagine her. I could not connect with her. Now, in the trance it was all so much easier. And you know it was all so visual in the trance... it definitely helped, and in those sessions in the trance, I was invited to see her. I saw her, I talked to her, and we could talk and have a chat and so on, something I could not do outside the trance.*

Sometimes participants just experienced these scenarios and then reflected on them during the talking therapy. Other times they described experiencing the imagined scenarios in the trance, while at the same time an observer part was watching these experiences and was reflecting simultaneously.

It seems that they were developing insight and integrating these experiences concurrently. Mandy's account below is explicit, describing how she worked through difficulties in relation to her father:

> *Looking at myself like an observer, it is almost like I am in the trance. I am an observer watching myself as a child with my dad. I am taking all*

of the negativity and literally throwing it off a cliff or blowing it up or something and then that leaves only the good stuff between us.

I understand that Mandy was discharging affect and dealing with both the good and bad internalised self-object (Dad). I think that she needed in childhood to hold onto an image of Dad as good, in order to cope with the tormenting experiences. So the intense fear and rage felt out of Dad's cruelty were out of awareness dissociated and held in a suppressed emotional ego states. From Mandy's descriptions I think that she carried out deep processing in order to integrate these experiences after releasing the embodied affect.

Fourth master theme:
The transformational process, what made the difference?

This master theme encapsulated participants' experiences that emerged in relation to the therapy they considered influenced their transformations. This comprised the following sub-themes:

- Participants' theory of change
- Moving from dissociation to connectedness
- The commuting self: reflecting and experiencing

Participants' theory of change

Participants appeared to have throughout the therapy clear views about what they thought had been important in contributing towards their transformation. They all mentioned that their positive relationship with the therapist was important in

allowing them "*to trust* and to "*give more*" of themselves during the therapy. Alice described it:

> *I think because you're, you're made to feel so relaxed and um that's going to impact because you're relaxed… I could get more out of my therapy. If you're willing to give up more, if you're willing to open up more, because you feel in a very safe place.*

I gathered from all the interviews that this positive relationship with the therapist was something like the foundation, the secure base that encouraged and supported the participants to progress their work.

However, the data shows that from the participants' perspective, the relationship with their therapist was not the sole element involved in facilitating their transformation. They all described other specific works done in the therapy as significant in furthering their processes. Such as the specific therapeutic tasks chosen by them as significant in furthering their progress were related to the participants' own notions of what was wrong with them and what it was, in their views that they needed to improve.

Participants described what I understand to be the ego state work as central to their transformation, though this was not the language they used. For example, they described having pending (although all different) inner child issues that needed to be looked into. Only George used the expression "*inner child*", all the other participants talked about "*myself as a chil*d", "*little me", "young me", or "teenager me".* They all described carrying out different types of work related to their own individual needs. For Gwen and Gabby this was integrating their teenage experiences. In the case of George, it was acknowledging and validating his inner child. In the case of Mandy, it consisted of doing justice to "little me"

and having her adult part coming in to take care of her:

> *As I look at myself as a child having somebody, having the adult me coming in to guide her, to take care of her, and that sense of caring is almost as if as a child I had someone to guide me through the bad staff in such a way that make me realise that there isn't anything bad that I cannot get through or that cannot be fixed. That I am not pathetic or weak or rubbish or, you know, cannot do everything perfectly. It's just trying to let go, the "little me" letting go of those insecurities.*

Here Mandy was concurrently experiencing and observing breaking the loneliness, confusion and lack of support held in her child ego state.

In Alice's case it was the fostering out in the trance of her inner child until she was ready to accept it:

> *We did, we did some therapy about a separate part of me that came up in the trance and it was basically like a little Alice. She was a handful…Yolanda [therapist] said I'm going to take little Alice and take her with me if you want, and um I'll look after her and then when you want her back, you can ask for her back… when I eventually did ask for her back it was the end of the therapy we had. The vision I had in the trance was very, very clear but this, this little girl it was like by a fire, little girl with red hair. I've got red hair, but, but kind of serene and chilled and happy and just a very gentle little girl and, and then remembering Yolanda talking [in the trance] about it and starting to say, you know, she's been very well looked after, she's very happy and it was exactly the person I'd, I'd just had this vision of before she even said anything and then to be ready to take her back as, as something to take responsibility for and to be part of you again. That was really quite um, that was quite special. I don't think it could have happened in any other therapy, it was very much the vision I had, in the trance. That was quite amazing.*

Another aspect of the therapy that was expressed as significant by participants in furthering their change process was working with their unfinished business. These experiences were reflected upon during talking therapy, trance work or both and then addressed experientially in the trance or vice versa. For Ken and Lucida this aspect involved achieving closure of their delayed bereavement processes. In Lucida's words:

> *The most important aspects of the therapy were to enable me to grieve for my mother. I needed to grieve so that I could go forward, and I was able to do that in the trance.*

For Willow and Gwen, this aspect involved closure of an abusive relationship.

Participants expressed that the experiential work in the trance was central to their healing process. Whether they said they felt they were in an altered state of consciousness or not, they all reported using hypnotic phenomena. For example, Kim considered herself "*totally conscious*" and able to work through her fear of death with intense guided imagery. Both Lucida and Alice said that they felt conscious and much focused during trance work, but they both described having had good clear visions/hallucinations and were able to work well with hypnotic phenomena. As Lucida said, "*I will never forget those visions".* She expanded:

> *I saw an image of myself. It wasn't me, but the image had always been me. But then I knew that I was on the road to recovery. I derived great strength from it, great inner strength and belief.*

I identify that in Lucida's vision she has accessed a true nurturing ego state, a source of powerful inner strength. *In Willow's case it took the form of a tree:*

> *It always took on the same form, like this big oak tree. You know, like really deep roots, and very strong, you know, lots of foliage and that kind of thing. So yeah, so I think because I was in this sort of semi-conscious state, this kind of... We did this imagery work that it was easier for me. It was easier for those images to come rather than for, you know, in a wakeful state and talking to her [therapist]. I found that sort of after the sessions that imagery stayed with me... really stayed with me in difficult situations and in situations previous to the therapy in my mind that I would have found very difficult or emotionally trying. Some times that imagery just popped into my head and it would be like "oh" you know, "oh the tree appeared". It sounds a little weird but it was, as if, the tree is here so everything is going to be fine.*

Half the participants attributed their progress to trance and talking therapy working together. In Willow's words:

> *I think the combination for me was key. I don't think I could have done, I don't know, I don't think I could have done the trance therapy without the talking therapy. But then, I think, just the talking therapy wouldn't have addressed my issues in as effectively. I guess is the combination.*

The other half of the participants attributed it solely to trance work, as Mandy said:

> *I had a real sense of awkwardness a real sense of inhibition basically; I think that to sit here to discuss how I was as a child. Actually it is just easy to say I was like this or I was like that, but I didn't realise I was, until I was in the trance. That is the thing. Those things didn't come up until I was in the trance. So, I wasn't conscious of them.*

None of the participants attributed their progress to talking therapy alone. However, from the data it would not be possible to apportion the degree of trance work or talking therapy that contribute to a particular therapeutic shift as both process appeared to influence each other.

A clear pattern emerged from the data showing that the participants (Mandy, George, Ken, Gwen, Gabby) who saw trance work "*as core work"* were also the participants that said in their interviews that during the trance work they have experienced a clearly altered state of consciousness. Mandy described this:

> *I know everything I am saying but is almost like I am not, my brain is not making my mouth say it which it is the way it is, it but is as if I am knockout in a way but awake at the same time. It is nothing I ever experience before the close I can describe it to you is as if someone was lying in a bed with you and you are almost in the verge of sleep and your are answering them but you don't know what you are saying to them but I actually do know what I am saying and can come out and remember.*

Interestingly, her presenting problem, ten years suffering from bulimia nervosa stopped after the first session. She said:

> *I stopped completely yeah I cold turkey I wasn't forcing myself either. Literally from the minute I walked out I didn't feel any need to throw up and then from week to week you just get stronger and stronger.*

She said she could not explain this change alone in terms of her capacity to enter into trance:

> *I am very sceptical; I didn't actually think it was something that would work for me because I have tried hypnosis before and it's just was an expensive waste of money.*

In her interview, Mandy reflected on the reasons why she thought her bulimia symptoms had stopped after the first session. She mentioned she has been free of it ever since over two years ago:

> *[in trance] you kind of run through your experiences and pinpoint exactly what it is that makes you who you are. And makes you act in the way you do.*

She considered that perhaps the relationship with her therapist might have contributed towards her shift:

> *I seem to fall into the trance more easily with Yolanda. I do not know it is the voice or um, the weird thing is I did notice that there was a similarity in the method in trying to take you under to the last therapist I saw. Felt completely, I felt detached with the other therapist. While in here I feel involved in the trance itself. I don't know if it is the room. I don't know I do think it is Yolanda. That there is something about her that is really calming very healing you feel you can trust her with everything you say which you should be able to do with a counsellor. There is something, I don't know, un-clinical about her, which I felt the other therapist was not. She was very much like a doctor or psychotherapist. I didn't feel like telling her anything!*

I explain Mandy's experiences, in terms of the positive connection with the therapist being a possible contributing factor in her moving on. I think that it might have helped her to give herself permission to go deeper into her inner processes, she said:

> *I haven't even thought about doing that [bulimic cycle] in well, literally from the first session I saw her. Which to me is amazing because like it was such a – it dominated my life and I was never able to give it up because it is a control mechanism. And for some reason she was able to tap into what's making me feel the need to control in the first place, because it really isn't about food. She really helped me out from the very first time. The trance has the tendency to take you back into the factors that make you want to control things in the first place. And a lot of this to me was my relationship with my Dad and the constant need to be perfect.*

She described that her bulimia symptoms were removed after this; however she had a further nine months of therapy to heal her early relational trauma. Mandy expanded:

> *It was the actual making me let go of that need to please my dad. To let go of the need to um, um constantly... um reverse the feeling of disappointment he would have and to realise that I am an adult now. And I don't need to do that anymore so I think that's what um helped me so much.*

However, all participants described a range of different views about what other aspects of trance work had contributed to making a difference to them. For George it was vividly rehearsing and reinforcing a new way of being that produced a positive outcome:

> *Because you know that you have had that experience inside of you and it becomes a possibility for the way you can be in the future which you didn't feel before or you felt you had the fear anxiety that made you couldn't achieve that so it was a real, again, real physical sensation of feeling and I could feel my fingers curling... you become porous, you*

> *could feel this identity, this image and all the things it meant to you suddenly become part of you and you breathe into it and breathe deeper and after experiences like this I suppose, um, you know Yolanda then reinforced that, you know, reinforced these, these things near the end of the session.*

For Gwen, it was accessing and validating semi subconscious core feelings. For Alice, it was working with future visualisations of her that I interpret as 'the sense of a conceivable self'. She described this as very significant in contributing to lifting her depression, by giving her hope, and the ability to believe in herself, and to accept her deep wants. Willow found seeing situations and her life journey from totally a different perspective to be significant in her ability to move on:

> *Look at certain issues in a very kind of, intense… in a kind of a non-logical way.*

Furthermore, present in all the interviews was the notion that the participants perceived the locus of agency for therapeutic change as located within themselves, rather than in the therapist's skills or emerging from the client-therapist relationship. They used phrases such as: "*I've learnt the skills", "I feel now that I have matured", "you have to do all the work she guides you", "this journey was a feeling of growth and learning", "it was me doing it", "whether that is part of therapy or that is part of getting older as well". Furthermore, "I was able to combat it and make it to go away on my own", "it is, about self- belief and self-love",* "*I was able to physically express the grief in the privacy of my own home".*

I theorize that the participants' reflections of their changes seem to indicate that in their therapy they went through a change process that involved a range of different little self changes.

Moving from dissociation to connectedness

Participants perceived as significant in their process of change the intrapsychic work that resulted in a movement within the self towards connecting previously dissociated self-states. Their accounts describe acquiring a sense of connecting with parts of the self that felt disconnected prior to therapy. Participants experienced this as a central element to their healing. For some of them, it was connecting with their child and teenager parts. Others described having reconnected with their body or body parts. They all stated that once this internal connecting had taken place, they felt better about themselves and more able to connect to others. Gabby illustrates this:

> *Before therapy, um I was stuck at sixteen. I was in a twenty seven year old body but I was sixteen in my mind… so the teenager from the past got a chance to see what I, what she will achieve in the future. That, you know, I am grown up into a, a good woman, with good morals so it is nothing to be um scared or unhappy about, because when I was sixteen I was very, very unhappy ,very stressful times. So, I interacted these two together. I can feel happy right now.*

George reflected about what he gained from the internal dialogues between different self states:

> *How was that experience of speaking from these different parts of yourself?*
> *It gave me a lot of insight, gave me a lot of understanding of the experiences going on for me at that time. Helped me understand, helped me accept what I was feeling.*

It would appear that perhaps the mind capacity to access, reflect and co-assemble affective, somatic, cognitive and behavioural information contained in the self states helped the participants to gain a sense of intrapsychic harmony that catalysed a positive overall self organisation.

The commuting self: reflecting and experiencing

Participants experienced as significant in furthering their inner processes and contributing to their healing a movement through the therapy. This involved a movement back and forth between two core self-activities namely: reflecting and experiencing. Reflecting appeared to underscore deep insights that the participants developed about themselves and others during their therapy, and how they came to understand their problems and current feelings. I think that this allowed participants to create a meaningful self life narrative that put their experiences into perspective. In Kim's words:

> *It finally feels like I have got words to the music that's been playing*.

George encapsulated it:

> *This journey was a feeling of growth that I was learning more and more and more about how the stuff from the past was keeping me stuck in the here and now.*

I assess that the therapy assisted the participants in the process of developing further their "reflective function" (Fonagy & Target, 1997). This is captured in Gabby's account as she reflects on the anorexia nervosa she suffered when she was 16 years old:

> *Why did I do that to myself? Why my body or my mind went to such extremes, to protect me or to harm me? I think you always... Your mind or your body protects you, but I think so it's just a really unusual way. Everyone has a ways to deal with the situations of stress. Some people cut themselves and some people over-eat, under-eat or drink.*

Experiential work appeared to be as important as the reflective work in progressing the participants' inner process, as described by Gabby:

> *In a trance we had um, I um, that was really, really vivid, um because I had a panting rage, a lot of panting. My arm was numb because I was clenching it. I didn't know it was so much anger and then we used, used a metaphor. As I am a sieve so the anger is just pouring out and pouring out of my pores, everything, just anger coming out... so there is no longer the anger towards myself.*

It seemed that Gabby was not only discharging dissociated affect, but also she was rehearsing feeling and processing affects, and in doing so, fostering a capacity for self regulation and psychological integration between her and disowned aspects of self. I think that reflecting and experiencing, and vice versa, facilitated balancing the participants' intra and inter-relational universe, in addition of placing back together the jigsaw puzzle pieces of their life journey. I think that it helped towards the development of a more integrated stronger self. In Gabby's words:

> *We dealt with the anger and I accepted the way I am and I accepted my parents. I think so it started becoming easier, I think so anger was rage, was such a big cloud over me that it took a part of my personality… So I think when we lifted that I think a lot of puzzle pieces started pulling back together and coming into the picture.*

Fifth master theme:
The relationship with the therapist, the guide

This master theme concerns the participants' experience of the therapist and the therapeutic space. It involved two sub-themes:

- Good relational space.
- Someone is looking after you.

A good relational space

The therapeutic space appeared to be experienced by the participants as a good relational space: safe, within a person to person or nurturing relationship, with an

even power balance during both talking therapy and trance work. George encapsulated it:

> *There was that clarity very much the case of you know this is something we were doing together, rather than the you know the therapist imposing it upon me. That was good, because you know that makes you feel relaxed before you even go into the relaxed state. You feel confident.*

And Alice described:

> *I think Yolanda makes you feel very safe anyway, and I feel this little room is a very safe, safe environment, and she's very good at making you feel very relaxed... And um safe and she wants to kind of really understand where you're coming from, and that works in both the talking and in the trance.*

Someone is looking after you

The therapist was perceived by all the participants as caring and trustworthy. Alice expanded:

> *She's [therapist] extremely kind and extremely thoughtful and extremely, perceptive um, and very aware of possibilities of how that may make you feel... and will do her upmost to make sure you feel safe, and cared for.*

Participants felt guided during both talking therapy and trance work. They all reported experiencing a good relationship with the therapist very early on in the therapy. Willow said this:

> *I immediately. From the first session I trusted Yolanda [therapist]. I felt very comfortable with her. I felt very safe with her. I felt completely, totally like [she] was one of the most empathetic, she is the most nonjudgmental person I had ever met in my life. I mean, yeah, I just felt like immediately like I can tell her anything and she is not going to make me feel bad about it. Not feel like she is not going to like me or you know, yeah. I felt immediately like I could trust her and it was a very safe environment.*

The participants described finding the therapist supportive and warm. Such as below in George's excerpt:

> *Genuine, real warmth...really, really supporting me,*
> *felt supported, nurtured, held and encouraged. I used to look forward to coming to sessions because there was a relationship in my life where I was totally accepted.*

I gathered from all the interviews that the therapy unfolded within a safe holding co-created relational environment. I think that it fostered positive experiences of self affirmation and psychological integration, via shared states of affective resonance between participants and therapist.

They all found the therapist attuned to their emotional needs all the time, but none of them found the therapist more attuned during the trance work.

From Alice's account:

> *Yeah very attuned*
> *Do you think she was more attuned to your needs when you were working in the trance or during the talking therapy?*
> *I didn't see a difference*.

I think they perceived the therapist's emotional attunement overall as good enough to feel safe and trusting of the therapist and the process, in both talking therapy and trance work. As Kim said, *"she was connected all the time".* I make sense of the participants' experiences of the therapist as: that they just needed a "good enough emotionally attuned therapist" for them to carry out their work. I was very surprised by this finding as I perceived myself as more finely attuned to the participants during their trance work. I reflect that maybe my perceptions came from my own projections, related to what I wanted to think and feel when, as a client, I was working in the trance. Or, perhaps it is a phenomenon that is found in

me in connection to the language used during the trance. During the trance the therapist communicates in a soft, low voice, but using normal adult sentences. The client, however, speaks in an even softer voice. A telegraphic tone, using concrete almost childlike language. I think this might trigger in me a perception of vulnerability in my clients during the trance work that activates a deep protective feeling towards them. I will come back to this divergent perception between clients and therapist in the Discussion.

5.2 THERAPIST'S EXPERIENCES

This section presents the findings of my generic interview as the therapist to the participants, in which I describe my experience of the participants' experiences in therapy. Two master themes emerged from the phenomenological analysis of this interview. These are: Threading beads and Facilitating factors.

Threading beads

This master theme contains all my experiences of the participants' experiences of their therapeutic outcome and processes. These themes clustered under one main activity: re-*building the self*. This was encapsulated metaphorically by the image of threading beads together to make a necklace*: "putting together their life experiences in a narrative and working through the underlying dynamics behind their psychological distress"*. I stated that "threading beads" is:

> *A metaphor for rebuilding and strengthening their sense of self, by integrating experiences to the whole of their personality...I experienced the participants engaged in threading beads together, finding some crucial missing beads and seeing with clear eyes how some beads have become invisible and why others were non-existent.*

I expressed in my interview that my overall experience of the participants' therapeutic experiences was that it had been a positive experience. I had a sense that they had moved away from their presenting difficulties that brought them to therapy, and appeared to have achieved better way of being in the world:

> *I think that they not only recovered from the problems that brought them to therapy but in addition they appeared to have not only strengthened their sense of self but also they appeared to have developed a more resilient self.*

I also expressed that I had a sense that the resilience developed helped the participants to become more self protective, and prevented them from relapsing:

> *I assess that there was also a learning, which enabled them to spot in the present, the signs from the environment or from the inner self inviting them to become trapped again.*

I considered that participants developed the capacity to satisfy their self needs. I theorized in my interview that if the therapist is available and willing to follow the client, the client can use the therapist and the therapy towards the satisfaction of her therapeutic needs. This is similar to the way that the baby uses her mother if the mother is willing, within the mother and baby interaction, to satisfy her needs. I said that I had a sense that they have used the therapy in a resourceful way. The subthemes that clustered under this master theme were:

- Finding
- Completing
- Creating
- Discarding
- Learning

Finding: Refers to the tasks in therapy that I thought the participants had engaged with in order to become aware of the core self issues such as intrapsychic conflict, self worth issues, relational issues, and body issues. I said that "finding beads" refers to:

> *The tasks carried out in therapy that I believe helped them to develop self insight, and opened dialogues between self parts. For example a dialogue between dissociated affect of a child ego state with the adult ego state.*

Completing: Refers to the therapeutic tasks that I thought the participants had pending and were holding back their life in the present. I said:

> *Tasks that I thought the participants carried out to complete unfinished business. Such as closure of delayed bereavement processes, overcoming pattern of relating that were leading to abusive relationships.*

Creating: This subtheme refers to the therapeutic tasks that I thought the participants were engaged with during their therapy in order to create new coping resources:

> *Yes, they carried out healing task that involved the construction of new meanings, insights, generating new memories, new way of connecting with self and others. For example, creating a safe place where to go to when fearful.*

Discarding: A sub-theme that refers to the therapeutic tasks which I considered the participants engaged with during their therapy aimed at moving on from the usual patterns of relating that were unhelpful. I said:

> *Accepting, letting go, and choosing to forget unsuitable patterns of being' patterns that were self limiting.*

Learning: A sub-theme that captures my experiences of the participants' therapeutic task that I experienced they engaged in learning and rehearsing new ways of being in the world. I explained:

> *I believe they learned by rehearsing many times new ways of being in the world. For example, practicing many, many times how to self sooth, I think this way they learned how to regulate affect.*

FACILITATING FACTORS

This master theme encapsulated all of my experiences of the participants' factors that contributed to the participants' process of transformation. The subthemes that contributed to this master theme are as follows:

- Trust building and reflecting in talking therapy
- Experiencing and reflecting in trance work
- A safe therapeutic space and a good relationship with the therapist

Talking therapy and reflecting

I described in my interview that I perceived the participants' use of talking therapy as the place to: "*build up trust", "disclose", "reflect", and "create a narrative"* by putting into words experiences that they might not have articulated before. These included*: "feel seen and heard, reflecting in the presence of an emotionally attuned other", "disclosure of the past and feelings", "safe expression of affect, feeling supported and cared for".*

T**rance work/experiencing/ reflecting**

I described experiencing that all of the participants felt that trance work was a comfortable process in which they could work experientially and reflect on their deeper issues, which were the underlying dynamics of their distress. I described my perception that the participants' trance experiences were facilitated by their departing into their trance journey from a relaxed position.

> *A calm place where they could carry out deep experiential work.*

In my interview I considered that the participants experienced that the length of the session varied, even though all of the participants have the same 90 minutes session taken by the clock. I thought that this was not an issue for them; I believed that they just wanted a productive session. I also thought that the participants' level of consciousness during trance work also varied widely, but I did not notice that it made a difference to the working with their issues. I expressed in my interview:

> *How conscious do you think they were?*
> *I think that is a difficult question to answer. I think that it varies so much from person to person. But I experienced that they all use hypnotic phenomena in different levels of depth.*

When comparing the process of therapy during talking therapy and trance work I expressed that both dimensions in therapy complemented each other. I said:

> *I think that the participants considered that these two dimensions of therapy are like two sides of the same coin that: talking therapy builds the connection between the therapist and the client. Which I think they considered, being the ground and the vehicle for the therapy to unfold. And the trance work allows for deep experiential and reflective work which can create profound awareness and new learning.*

I added:

> *I think that reflecting with the therapist in talking therapy could have been considered by them to have expanded their awareness. And, reflecting during the trance work, while held by the emotionally attuned therapist, could have been considered by them to have facilitated deep intraspychic insight and reconnecting. My sense is that these perhaps were their experience.*

The therapeutic space

This is a subtheme of the master theme "facilitating factors". "The therapeutic space" captured my perceptions of the participants experiences related of the relational space. I described them in terms of: *"supportive", "safe", "holding", "transparency", "containing", "nurturing", "positive"*. I explained in my interview that I experienced the participants as feeling safe within the therapeutic space, and that I believed this encouraged them to trust the process of therapy, allowing a deepening of their inner processes. In my experience of the participants' experiences I think that they did deep work at a profound level, the level of their out of awareness internalized schemas of repeated interactions Stern's (1985) RIGs. I think this process was different for each participant depending on their circumstances. As I said in my interview:

> *I remember experiencing that they went through a deep process of readjusting their out of awareness core relational blueprint. This strengthened their sense of self and improved their ability to deal with the negative patterns that were keeping them stuck.*

The therapist

This is a subtheme of the master theme "facilitating factors". "The therapist", captures my sense of the participants' perceptions of me as their therapist. In my interview I described this as*: "positive", "open", "receptive", "non-judgmental",*

“guiding”, “supportive”, “present”, “caring”, ”nurturing”, “emotionally attuned”, “person to person relationship”.

With regard to my level of emotional attunement with the participants, I consi*dered that th*e participants perceived me as more attuned during trance work. I said:

> *In the trance, I think I am more emotionally attuned. I need to be intensely focused so I can see for example any little changes in their breathing or a muscle tensing, a tear, a slight change in their facial expression.*

Overall, I expressed that I experienced that the locus of therapeutic change was placed within the positive quality of the therapeutic relationship. I experienced the participants’ progress in therapy mostly due to the positive and safe relational space. I stated:

> *I understand that central to the change process for the participants was the therapeutic relationship. That it really was the ground and the vehicle for change.*

6. A REFLEXIVE ANALYSIS:
MY INTERVIEW AND MY OWN PROCESS:

6.1 Reflexivity

In this section I focus on how my own presupposition and pre-understandings have influenced my dialogical relationship with the participants' accounts and reporting of project's findings.

As a result of my pilot study, I re-adjusted this project's design by adding an interview of myself as the therapist to the participants. During this interview I explored my experiences of the participants' therapeutic experiences, within the framework of their therapeutic processes and outcomes. The rational for this was based in an understanding of my position as an insider researcher and the numerous complex layered interactions between the researcher and the researched. My aim was to increase the awareness of my fore-structures, beyond naming and acknowledging my preconceptions. I have aligned myself with Gadamer (1998) and aimed to make myself more transparent. I considered that my interview facilitated my research endeavour through the data analysis, increasing my transparency and facilitating the fusion of my researcher's horizons with the participants' horizons (Gadamer, 1998). I believe that my interview assisted me in this process by keeping an ongoing comparison between the emerging participants' experiences and my therapist's experiences of their experiences.

6.2. My interview

I noted in my research journal that immediately after sitting in the client's seat in my consulting room for the purpose of my interview, I experienced a strong déjà

vu feeling of having been a therapy client being interviewed about my therapeutic experiences. I felt vulnerable at the thought of having to remember intense and sometime painful memories and processes. I felt I wanted to be very cautious in disclosing information to the person sitting in front of me who sounded like a therapist, but therapy was not the aim of the encounter. This awareness helped me during the data analysis to empathically understand why none of the participants revealed to the interviewer their life's traumatic events.

I also found that I felt much empathy towards my former clients who had declined to participate in the research. I thought it would be hard to become a participant in this research as it would potentially involve them looking again into inner difficult processes that had been work through long ago. On the other hand I experienced gratitude towards the courage of my participants who had agreed to participate. I also felt protective towards them. At the end of my own interview this led me to go through again thoroughly with the interviewer our agreement to protect the participants from any discomfort and potential distress as far as possible.

My interview began with the question *"what do you experience when a client enter the consulting the room?"* The open ended questions, such as this, focused on my experiences and what I thought my clients' experienced in the trance and in talking therapy. On reflection I thought that the content of my interview was much shaped by my therapeutic approach. I did try just to experience what I felt in my mind and body in response to each question, but when I articulated a response, this emerged in the language of my therapeutic approach. I could not

dissect my sense of my clients' experiences in an experiential vacuum. I have developed an understanding of my former clients' experiences in a particular psychological conceptual language. This showed me the consequence of my historicity (Heidegger, 1962), my psychosocial situatedness (Gadamer, 1998). Thus I could not help but experience and interpret the world from a particular perspective, and could never fully escape this subjectivity. I registered early in my journal that I expected that my "for- understandings" would be constantly present and potentially impacting the data analysis, and I decided to maintain an ongoing alertness in order to spot and mitigate these when occurring.

6.3. My process

Given my favourable views of the application of clinical hypnosis in therapy, I attempted to maintain awareness of the way in which my stance on this topic may have influenced the data analysis. For example, I checked for any over-reliance on my part for reporting participants' positive comments about the therapy in preference to their negative comments, with the aim of providing as trustworthy an account as possible.

I attempted to minimise my own subjectivity in the data gathering by employing an independent Interviewer who carried out all of the participants' interviews. Hopefully this reduced the effect of my own influence on the data collection in terms of participants feeling they had to provide the 'right'/'positive' responses, although it is impossible to know to what extent they still felt they had to.

The Interviewer did not have an especially positive attitude towards hypnosis which

affected her questioning. The questions sometimes focused on negative aspects of hypnosis concerning, for example, whether the participants ever felt pushed in a particular direction that they did not want to go, or whether they felt under the power of another, as if they had no control. Asking such questions seems to have had the effect of eliciting very positive material regarding participants' experience of the therapy in order to clarify the nature of their experience. Nonetheless the interviewer expressed these questions as a natural curiosity towards a phenomenon that she had little knowledge of, and so potentially, the interviewees felt they were the experts providing rich descriptions.

During the analysis of the participants' interviews, I found myself thinking that I would have liked to have been able to carry out the interviews of the participants myself. After incorporating the learning from my pilot study, strangely enough perhaps it would have been possibly that the participants might have produced even richer material by dwelling more on the depth of the work done rather than spending time describing to the Interviewer what the trance felt like and how they got into the trance and how conscious or unconscious they were and so forth. An independent interviewer was needed for trustworthiness, but I will never know if it was at the expense of experiential depth.

During the data analysis my expectations of what I thought I would find in my participants' accounts were based on my memories that had been formed from my personal experiences and from my clients' work. My expectations were generated out of a very wide sense that I held that clinical hypnosis was as a useful malleable tool in a therapeutic process. I expected some participants to have similar experiences to mine. I also expected the opposite based on my knowledge and

experience of how very unique and different humans are from one another and how variable is the phenomenological experience of the trance phenomenon.

I expected a wide experiential variance ranging from positive experiences similar to mine to indifferent experiences and negative experiences in connection to the participants' therapeutic processes and outcomes. My aim was to explore openly and widely so I could learn from my participants what their therapeutic experiences had been and what these experiences have meant to them within the uniqueness of their life journey.

During the data analysis and data presentation my therapist interview was extremely helpful to keeping my fore-understandings in view. Every time that I doubted the quality of my interpretations I went back to the text, the participant interview and to my interview to compare and contrast experiences and I then grounded my interpretations in the participants' accounts.

It was difficult to hold the boundaries and not let my clinical observations based on my clinical experience of the participants to surface during the analysis and when presenting the findings. I could not help my clinical observations coming to mind based on the clinical knowledge that I had of the participants when analysing the data and presenting the findings. I mitigated this tendency by strictly validating all the themes that emerged out of the data analysis by matching them with corresponding participants' verbatim quotes. I also developed a system that can be described as a kind of Socratic questioning technique which I applied in the revisions of the emerging themes, master themes and findings presentations. It

consisted in asking myself "*is this theme or idea researcher or data determined? "What is my evidence*?" I looked for answers by returning to the interviews transcripts and to my interview. I also kept a record of my unresolved doubts which I discussed with my peers.

At the same time, I accepted in line with Gadamer (1998) and Heidegger (1962) that my presuppositions would to some degree be embedded in the phenomenological explorations of my participants' experiences. I accepted them as part of the process of co-construction the data out of the participants' accounts. This is all part of our (researcher and participants) engagement in the hermeneutic circle of understanding, in which we all work together to bring life to the experiences being explored; amongst other things by the use of imagination in the construction of meaning as an intersubjective phenomena (Laverty, 2003).

6.4. Experiences: Participants and therapist

After all the interviews had been analysed I carried out a comparison of themes between the participants' master themes and the therapist's interview master themes. When contrasting the participants' and therapist's experiences as distilled in the master themes I classified these experiences in terms of showing agreement, partial agreement and disagreement between them. Table 6 summarizes the main issues.

Table 6. Comparison: participants' and therapist's experiences

	Participant's experiences	Therapist's experiences
AGREEMENT **Meaning & outcome of therapy.** **Experiencing Trance work (TW).** **Quality of the therapeutic space & relationship with therapist.**	Moved away from lost and trapped self. Recovered. Improved quality of life. Developed stronger self. TW felt: focused, relaxed, effective & pleasurable. Allows working with deep self processes & memories. Commuted from reflecting & experiencing using trance phenomena & guided imagery. Perception of time felt altered. Perception of altered consciousness varied. Therapeutic space felt: safe, holding. Therapeutic relationship: positive. Therapist felt guiding, supportive caring, nurturing, encouraging & trusting.	Rebuilt sense of self. Developed resilient self. Got better. TW: focused, relaxed, enjoyable & effective. Worked with subconscious patterns & processes. Used hypnotic phenomena & guided imagery during experiencing & reflecting. Perception of time altered. Phenomenology of consciousness varied. Therapeutic space: safe, containing. Therapeutic relationship: positive. Therapist receptive, caring person to person. Early strong working alliance.
PARTIAL AGREEMENT **Dual process: Talking therapy (TT) & trance work (TW).** **Therapeutic tasks.** **Function of the relationship with therapist.**	Dual process: half of participants felt TT &TW complemented each other. The other half expressed that TW was more key in furthering their inner processes. All agreed that main tasks carried out were: finding & working through negative inner patterns of relating, integrating dissociated parts of the self, finishing unfinished business, developing skills to manage emotions & self reflect. Relationship with therapist felt important, the foundation for the work.	Agreed with half of participants that talking and trance work are two sides of same process. Agreed that main therapeutic tasks were: developing capacities to regulate affect & the reflective self. Finishing pending self business. Insight of and learning to move away from maladaptive patterns of experiencing. Integrating dissociated ego states. Relationship with therapist as important, essential ground and vehicle for change.
DISAGREEMENT **Therapeutic Change.** **Therapist's emotional attunement.**	Locus of therapeutic change within the self. Felt: therapist's emotionally attuned all the time. Equally attuned during TW&TT.	Locus of therapeutic change within the relationship between participants and therapist. Therapist felt more emotionally attuned to participants during TW.

I was very surprised by participants' and therapist's divergence of experiences. I expected divergences but not regarding the locus of therapeutic change and the therapist's level of emotional attunement during trance work. I was not expecting to find that all of the participants placed the locus of therapeutic change as located within the self. I considered the relationship with the therapist to be the main vehicle for transformation I have placed it at the heart of my therapeutic model, and expected participants to place the relationship with the therapist at the centre of their perceived change process.

Conversely participants attributed their processes of transformation more to their own capacities to do the work, to discover their needs, and to learn and unlearn patterns of being. The participants placed the relationship with the therapist more in the background as very important but as the foundations on which to erect the building blocks of the therapeutic work. The participants also attributed their transformation to experiencing a natural process of growth and maturation. I appeared to have been blinded by my deeply relational approach. Comparing therapist's and participants' master theme made this awareness poignantly tangible. The positive relationship with the therapist appeared to have fostered a range of opportunities for the participants' to exercise their experienced self agency.

I was also surprised that all of the participants stated that they found the therapist equally emotionally attuned to them all the time. I held a powerful sense that the participants would perceive me as I felt, more attuned emotionally to them during trance work than in talking therapy, consistent with research findings (Howe, 1989, 1996; Orlinsky et al. 2004; Singer, 2005) that suggest

that the therapist's ingrained deep belief about a particular aspect of therapy will have an effect on how they do therapy, and it can impact how the client uses therapy. In this particular therapy these divergent experiences were not detrimental to the therapeutic process. However, they spoke about the potential existence of divergences of experiences between therapist and clients that can potentially influence negatively the therapeutic process. This finding made me more alert in therapy towards looking for any potential experiential divergences with my clients.

6.5. Impact of the researched on the researcher

During this study's process I expected to learn from my former therapy clients about their experiences. I also expected to learn about myself. However I did not expect that out of this learning the way I practice would be transformed so profoundly. I acknowledge as I reflect on my own process that I have changed the way I use clinical hypnosis. I believe that I used to use it more as a rigid tool, but now use it as a navigational instrument, a trusted compass that gives me the cardinal points showing me where the client needs to go. I am increasingly using more indirect hypnotic imagery to facilitate the client's opportunity to create her own target destination and pathway. I consider that I have become more attuned and alert toward a present moment therapeutic direction. I am applying hypnosis in a more flexible manner, more sensitive to the client's uniqueness, much more Ericksonian (Erickson, 1980).

Furthermore this project modified the way I work with trauma. I used to focus on preparing the client for the safe exploration of the traumatic past, aiming for

the integration of these experiences. I have moved the focus from the past to the effect of the trauma experience in the present. I trust my clients more in relation to their self-theories and intuitions.

Therefore, I am much more client-lead in the sessions. This is allowing a flexible space for my clients to signal to me, even in the smallest way, their healing needs. I trust that they can show me the ego states that are active in the here and now seeking healing. The ego states that are perhaps phobic, OCD, somatoform, protectors-persecutors and so on, that are keeping the trauma experiences away from integration by keeping the maladaptive dissociations.

This research project also modified my stance regarding the therapeutic relationship by expanding it. I am now not only working towards the co-creation with my client of a safe, holding relational space, but I am also incorporating the resourcefulness of my clients in guiding me to guide them to access a range of healing moments, moments of fittedness. I have learnt that these can be between self and other, for example client and therapist. But they can also be between self and self, or self and process, or self and experience (Fosha, 2009).

7. DISCUSSION

7.1. Overview

It has been argued that clients are well placed to generate highly relevant practice-based research questions and data by virtue of their direct experience of therapy (Gordon, 2000; Sousa, 2006). The challenge for therapists is to work out how to provide therapy that incorporates the clients' insights and theories about themselves during therapy as an ongoing process, so that we can become better therapists (Singer 2005).

This study's findings provide personal insights from therapy clients, in their own voices, about their therapy processes and outcomes when clinical hypnosis was used in every session. It is suggested that the clients' views of their experiences as receivers of therapy are important in the development and outcome of their own therapy. The findings seem to support the claims from the field that argues that a phenomenological study of the lived therapeutic experiences of clients can generate rich research based experiential material (Gordon, 2000; Sousa, 2006). This experiential material would not be accessible to us by quantitative methods, or by therapists' anecdotal accounts of what they thought went on for their clients during therapy.

7.2. Participants' experiences

The outcome of therapy was experienced as a positive transformation, deep enough to allow the participants to move away from their presenting problem and improving their quality of life. The participants did not describe their therapeutic goals and outcome using concepts such as rebuilding their sense of

self, as I would describe it. Instead, they referred to starting therapy from a position of a distressed trapped self, desperately wanting to feel better and achieving through therapy a sense of freedom from distress and an overall sense of wellbeing.

The participants expressed a felt sense of the therapeutic space as "*safe*", and *"holding*", and my attitude as therapist as "*caring"*, "*supportive*" and "*emotionally attuned"*. These perceptions were consistent with the reported positive therapy outcome. They were also in line with research findings that have shown the centrality in the therapy's transformational process of the positive client and therapist relationship (Norcross, 2011; Norcross, & Wampold, 2011).

The participants did not describe a unified position regarding the contribution of talking therapy and trance work in deepening their therapeutic processes. Half of the participants' experienced that talking therapy and trance work complemented each other. The other half of the participants thought that trance work was more figural and talking therapy was more in the background. For this latter group of participants the most important work done was in the trance. It may be that these clients had remarkable trance experiences due to their high hypnotisability, making talking therapy less figural. It is not possible to accurately assess whether trance work or talking therapy was more helpful to the participants, as both were intertwined within the vine of therapy.

The data also suggest that there were marked individual differences between the participants regarding what has been found to be particularly beneficial within a range of shared general factors. For example, in working with their inner child, one participant needed to foster out her inner child. Another needed to validate and listen to their inner child's experiences, and for another, it was experiencing that justice had been done for her inner child. It all depended on their own personal needs and what they thought was the matter with them within the context of their life journey. This determined the themes and task they choose to work on and how they progressed in their therapy. A wide range of different tasks and a variety of different ways of processing were described as helpful in deepening the participants' inner processes. These findings are consistent with research that shows the importance of attending thoughtfully to individual differences (Hubble et. al., 2010) and the client's characteristics such as strength and preferences (Cooper, 2008; Cooper & McLeod, 2011).

Overall the data shows that the participants placed their experienced locus of therapeutic change within themselves rather than the therapist's skills or techniques or with their relationship with the therapist. This study suggests that the therapist is required to be highly flexible and receptive in order to tailor the therapy to the clients' particular needs and perceptions. One of the findings that illustrates this well is that the participants felt that having an open agenda for therapy in each session was significant to their healing. This was the case in both dimensions of the therapy, but appeared more salient in trance work. For example, Lucida said that once in the trance, she spontaneously saw herself sitting by her mother's death bed. After articulating this in the trance her

therapy session focused on working through this issue. So her vision determined the content of her session, allowing her to begin tackling unfinished business that led her to achieve closure of a delayed bereavement process.

These spontaneous ways of bringing themes to the session were understood by participants and therapist and described in the findings as conscious, partly out of awareness or out of awareness needs seeking resolution at that moment. In general the participants described themselves as resourceful self-agents that choose how to use what was being offered (talking therapy and trance work). The participants' experiences suggest that their use of the therapy depended on their own hypothesis of what was wrong with them and what they needed in order to get better. This confirmed research findings (Bohart &Tallman, 1999; Orlinsky, Ronnestad & Willutzki, 2004; Singer, 2005) showing that clients have their own theory of change and understanding about their therapeutic experience, including how and why it impacts therapeutic outcomes. I conclude from this study that the therapist must place greater trust in the resourcefulness of their clients (Cooper & McLeod, 2011). The study suggests that the therapist is required to be particularly alert to what is being spontaneously presented, and so the session can be tailored to the client's inner healing needs in the present moment.

7.3. Possible usage of clinical hypnosis

This study's findings provide rich experiential accounts of what it was like for the participants to have experienced therapy in the trance. This subjective experiential material might not have been accessible to us by means other than

the experiencer's own account. The study supports research findings that proposed a phenomenological approach to investigating the subjective experiencing of clinical hypnosis (Woodard, 2003, 2004, 2005). There were a variety of experiences reported. These suggest ways to use hypnosis in the consulting room by the relational developmental practitioner and indeed also by practitioners that use other therapeutic models. Some of the possibilities that emerged from this study are listed below.

Trance working

Trance working was experienced **as** relaxing, pleasant and effective. This is congruent with hypnosis research findings (Abbasi et al., 2009). The participants also found it effective in furthering therapeutic processes and outcomes in agreement with published clinical experience and research (Flammer & Bongartz, 2006). The study suggests that hypnosis was perceived as valuable in achieving mind and body calmness, facilitating inner work. The participants reported that in the trance they felt very calm, and that it made them more receptive to deepening their inner processes. A sense of deep tranquillity is a well known feature of hypnosis (Benson, Arns & Hoffman, 1981;Yapko, 2003). It seems that the autonomic hypo-arousal and phenomenological calmness described experienced in the trance can be thought to have helped participants to focus away from the unvarying alertness and hyper-vigilance. The calmness described was accentuated by a subjective sense of safety through their usage of the safe place imagery. I understand this as a voluntary dissociation which can be contrasted with the involuntary element of dissociation associated with trauma (Kepner, 2003).

This work appears to be deeply calming, and I believe it assisted the development of self regulatory capacities and sense of self agency. I hypothesize that it can be used as a resource into the stabilization phase and stabilization needs throughout trauma treatment. This finding appears to be aligned with trauma treatment and hypnosis published clinical work (Janet, 1889; Phillips & Frederick, 1995; Schwarz, 2002; Van der Hart et al., 2006; Watkins & Barabasz, 2008).

Consciousness during trance

Participants described in the interviews their state of consciousness during trance work in different ways: a dreamy state of mind similar to the one experienced during meditation, a deep state of focus as being in almost another realm, an altered state of consciousness and nothing special, not different to when one is absorbed in a book. This is consistent with hypnosis clinical experience (Yapko, 2003). Because of the large range of possible phenomenological experiences, the term "trance" is not used anymore by some hypnosis specialists, such as Yapko (2003). However, I choose to use it in this study because it was the way the participants described it to me during their therapy and in their interviews.

The concept of "deep work"

Trance was experienced by the participants as deep work. Deep in the sense that allowed safe access to work through profound rooted patterns underneath their current intra and inter-relational interactions. That it allowed safe expression of negated feelings and the resolution of intrapsychic conflicts. Overall integrating what has been dissociated to the whole of their personality. This level of work via hypnotic phenomena has been well documented in the hypnosis field (Watkins &

Watkins 1997; Yapko 2003).

Intrapsychic work

The participants found the therapeutic process in the trance intrinsically different to the work done in talking therapy. The main difference stated was that talking therapy involved a two-way communication, self to other whereas, trance work involved more a self to self, ego state to ego state process of communication. Trance work was found to be highly conducive to intra psychic work because it seemed to facilitate authentic, open, internal dialogue between self states altering patterns of intra psychic tensions conflict and self castigation. I theorized the reported experiences using object relations and attachment theory. That the participants' internal attachment relationships, arising from interactions between their different subjective selves (internal subjects) and reflective selves (internal objects) became more harmonious by the work carried out via guided imagery. I hypothesized that clinical hypnosis can be considered to have activated the participants' brain attentional system in a manner that enhanced their accessibility to dissociated self states and trauma information not readily accessible.

I believe that the internal dialogues and emotional re-connections between the self states perhaps had helped them to develop an internal subjective-reflective dyad's capacity for mutual emotional attunement and resonance between ego states reflected in the participants' reported sense of inner calmness after the work. This is congruent with ego states therapists' published clinical work (Emmerson, 2003; Frederick, 2005).

The study suggests that the participants developed a safer, and steady, more open

internal holding environment. I think that such a more balanced internal environment appears to have in turn fostered capacities for self regulation and psychological integrations between participants previously disavowed aspects of the self to the whole of their personality. This can be considered congruent with hypnosis published clinical experiences of ego state therapists (Wakings & Watkins, 1997; Watkins & Barabasz, 2008).

Experiential work

The experiential work in the trance was reported by the participants to be vivid; that it took place via imagery which the participants reported felt real, intense and meaningful described as embodied experiences. I think it brought together previously disowned affects, emotional memories with here and now consciousness. The data suggests that imagery while in the trance generates rich embodied experiences permitting learning by intense rehearsal of experiences that felt real. Within a variety of learning experiences reported by the participants, I elucidate these experiences by using my knowledge of learning theory.

I can classify the participants' described learning as: having learned via classical conditioning, when learning to relax automatically by thinking of the word "now" which has been associated to mind and body relaxation. I think they learned via operant conditioning, by imagining choosing new ways of being reinforced in their mind by a positive outcome. I understand that the participants also learnt via reciprocal inhibition known as systematic desensitisation (Wolpe, 1958). This was the case of Kim in learning to control her fear of death by feeling her fear while her body was relaxed. Finally, I think they learnt via imitation in the trance,

the participants learnt by intensely observing their own experiencing in the future, past or present. For example, George said that watching himself behave in the way that he wanted to be in the future created an experiential learning that layered a new way of being for him. Alice watched herself being without depression in the future.

This phenomenon is potentially explained by neuroscientists in terms of the "mirror neuron" that underpins learning by imitation. It has been found that in addition to mirroring actions, the cell firing mirrors sensations, emotions, intentions and motives. The firing is involuntary, an automatic response to what another person is doing, feeling or intending, without requiring thought or language (Gallese & Goldman, 1998; Gallese, 2001; Rossi & Rossi, 2006). Bromberg (2011) linked this to the "implicit relational knowing". The activity of the mirror neurones has been linked to a range of mental phenomena such as empathy and the child's capacity to "metalize (Fonagy et al., 2004).

Visualising in the trance appears to have a deeper effect, linked to the power of guided imagery. Guided imagery is considered to provide direct access to a person's pre-linguistic symbolic imagination and processes driven by implicit memory (Siegel, 2012:325). According to the neuropsychologist Siegel, guided imagery allows a client to access emotional states in the form of images and embodied feelings. The fact that hypnotic phenomena appears to produce much intensified embodied experiences of the guided imagined material means they can potentially act as a hothouse of intense accelerated experiential learning and unlearning of ways of being.

Reflecting

Half of the participants found that reflecting during talking therapy was vital to their therapeutic process. However, reflecting in the trance was reported to be significant by all of the participants. They explained that reflecting in the trance intensified it, creating a higher level of reflecting out of intense experience processing. I believe it suggest that the participants' could have developed further the reflective self, the capacity to mentalize. Furthermore, perhaps it led them to expand their self and other understanding, compassion and affirmation of self.

During the trance the participants reported that they were able to experience at the same time as their observer part was observing and assessing their experiencing self. They reported this as highly insightful and experience processing that it helped them to place in perspective what they were experiencing now and then. This is, illustrated by Mandy's excerpt where she described experiencing herself like an observer, watching herself as a child with her Dad. I comprehend these accounts drawing from Siegel's (2012) explanation of the hidden observer phenomenon that is intensified in hypnosis. Siegel has suggested that the hidden observer phenomenon is an integral mode of processing by the mind. It is viewed as a third-party observing capacity, which has been called a "hidden observer", "observing ego", "internal helper" or "inner guide" (Hilgard, 1979; Spanos & Hewitt, 1980; Zamansky & Bartis 1985). The hidden observer shows itself under hypnosis as a mental output that makes comments about the person from a bird's eye view of the person's perspective. This function reveals:

> ‘The mind’s capacity for processing mindsight, the capacity of representing states of mind and processing the context of an experience over time’. (Siegel, 2012, p365)

Siegel (2012) states that the hidden observer is:

> ‘An integrative attempt of the mind, to create a sense of coherence across its own self states [ego states] through time and contexts.’ (p65)

This makes hypnosis a potential powerful therapeutic tool towards enhancing the mentalization process, the reflective function (Fonagy et al., 2004), linked to self and others empathy.

Furthermore, the participants reported moving back and forth from experiential self to observer self when shifting from talking therapy to trance work and within trance work. They also reported experiencing and observing/reflecting separately. The movement from experiencing and reflecting and vice versa has been described as significant in generating the reflective function and found to be central in the developing of our sense of self (Aron, 2000). In the process of experiencing, observing and reflecting oneself as both subject and object (Aron, 2000), it is thought that the infant develops a theory of mind, a sense of being and an “I” in relation to the “I” of others who have different thoughts, feelings, intentions, from herself (Fonagy et al., 2004). The participants reported that these experiences were heightened in the trance placing hypnosis as a potential relevant adjunct to therapy.

Subconscious processes and memories

All the participants described what I elucidate as having accessed subconscious memories and processes when working in the trance. They maintained that it occurred via guided imagery or spontaneously, depicted in the master theme "The uniqueness of trance work". The trance mode appeared to be a safe tool for accessing the subconsciously held embodied memories of the past. This is consistent with hypnosis theory based on clinical experience (Frederick, 2005; Watkins & Barabasz, 2008). The participants described different type of experiences. To expound this experiential range, I use the concepts put forward by Stolorow & Atwood (1999), described below.

The participants seems to have accessed what they called the" dynamic unconscious" (Stolorow & Atwood, 1999), the walled off material. For example, Gabby accessed an ego state holding the sadness and profound powerlessness that she intermittently experienced in relation to her father's abuse of her mother. In order to cope, it appeared that she had developed destructive self directed anger. In the therapy she released the anger directed it towards its original source and reunited herself with a sense of personal power, ending the long term internal recapitulation of the abusive dynamic.

It seems that they accessed the "pre-reflective unconscious, the organising principles that out of awareness shape and thematise a person's experience" (Stolorow and Atwood, 1999:367). For example, Mandy described accessing and working through, her inner need to please authority figures. It manifested in the trance as a familiar profound anxiety held in "little Mandy's" ego state (Phillips & Frederick, 1995; Frederick, 2005).

The participants reported accessing what I describe as accessing their nurturing self, "the hidden core of the true self" (Hirsch & Roth, 1995: 65). They described experiences that can be elucidated in terms of Hirsch and Roth's (1995) concepts. Lucida talked about visions that she saw of herself that were not herself from which she gathered deep strength, Chad said he accessed the inner truth of himself from where he was deeply feeling. Willow talked about her inner oak tree: when it is accessed her ego is strengthened. These ranges of experience are consistent with published hypnosis clinical experience of Ego State therapists although these therapists explain this type of accessed material in the trance in terms of accessing different ego states (Emmerson, 2003; Frederick, 2005; Van der Hart et al., 2006, Watkins & Barabasz, 2008).

Dissociation

The Participants' experiences suggest that hypnosis was a valuable tool for working towards the integration to the whole of their personality of ego states that has been dissociated. It appears to have facilitated the resolution of some of the participants' deep intra-psychic conflicts. This seems to support the Ego State therapists' reported clinical experiences that consider hypnosis an effective healing tool (Watkins & Watkins 1993; Watkins & Barabasz, 2008). It is as if through hypnosis, a dissociative state, the client can enter into the mind's capacity to dissociate which provides access to their ordinary and survival dissociative processes to heal. I think that dissociation is a protective structural psychosomatic function of the mind, in Bromberg's terms (2011):

> 'Dissociation is what the mind does. The relationship between self-states

> and dissociation is what the mind is. It is the stability of the relationship that enables a person to experience continuity as I.' (p2)

Clinical dissociative experiences are sometime confused with those of hypnosis. While the two experiences may exist together, they are not the same. Hypnotic absorption is an example of a dissociative process, but the absorption itself is not indicative of a dissociative disorder. Rather, absorption is an example of everyday hypnotic experience (Maldonado, Butler & Spiegel, 2002) and is part of the mind's capacity to experience the dissociative process. Pathological dissociation is the outcome of severe autonomic hyper arousal and affects dysregulation (Van der Kolk et al., 1996; Van der Hart et al., 2006).

Conversely, clinical hypnosis occurs in a controlled context and involves the intentional evocation of a special state characterised by focused attention and body relaxation. This is not new; ceremonies around the world seem to involve alterations in consciousness with dissociative features in healing as shown in anthropological literature (Spiegel, 2005). In my experience, when a healing imagery is felt experientially the deeper the dissociative state, the more positive cognitive and emotional changes can take place.

Neurophysiological studies on the similarities between hypnosis and meditation (Holroyd, 2003) are providing insight into healing in hypnosis. Evidence suggests they are similar in the phenomenology experienced and in the neurophysiology associated with those states (Holroyd 2003). It seems that the same brain regions (the anterior cingulated cortex) are involved and that similar brainwave patterns (EEG theta waves) are observed in the two practices (Holroyd, 2003).

Affect regulation

The participants' experiences suggest that trance works appears to have been a valuable tool for working with affect at all levels as described in subtheme, "Surfing the waves". They described working with an intensified mindfulness of the body's sensations; identified the feelings that had been excluded by noticing, tracking, observing to vividly discharging the action tendencies that the body wanted to do then. I label it as carrying out sensory motor processing (Schwarz, 2002; Ogden et al., 2006). For example Mandy became aware of the impulse in her body to push her father away and then via guided imagery, she pushed him off a cliff in her mind when she felt her mind and body were at the point of rage. Afterwards she felt at peace with herself.

The participants' experiences suggest that doing this work in the trance felt safe and was effective. I believe that hypnosis seemed to have permitted a careful opening of the participants' window of affect tolerance. I reflect that it appears to allow a close monitoring of the client's autonomic arousal, making it a safe method for working with affect. By including the body as a way into the experience to process trauma, it seems that the participants were able to work directly with sensations and movements and promote change in their cognition, emotions, belief systems and capacity for relatedness. This is fitting with published clinical experiences (Levine, 1997; Ogden et al., 2006). A similar type of work is well known in the field of hypnosis known as "somatic bridge and affect bridge" in Ego State therapy (Phillips & Frederick, 1995; Watkins & Barabasz, 2008).

I comprehend the participants' experiences described as processing affect by using

knowledge of trauma treatment. I reflect that the effect of trauma and maladaptive attachment tendencies is to narrow the window of affect tolerance and it is essential to safely expand these boundaries. Procedurally, I believe, hypnosis appeared to have assisted the participants' expansion of the window of affect tolerance and in developing the ability of affect regulation. I think it did so by using the capacity in the mind of intense mindfulness.

Mindfulness is a strategy aimed at opposing repression and avoidance. It has been associated with greater activation of the prefrontal cortex and greater deactivation of the amygdala (Stein, 2008). When practiced in the trance it appears profoundly heightened (Yapko, 2011). All of the participants mentioned accessing core embodied affect in the present, safely intensifying it and working though it to self soothing. Therefore, they appeared to have integrated dissociated emotions, increased the capacity for positive affect and challenged negative embodied procedural tendencies with new actions. The participants reported experiences that were in accord with current published clinical work, showing that the activation and processing of these emotions leads to new resources, energy and meaning (Fosha, 2009; Trevarthen, 2009; Bromberg, 2011).

During the therapy the participants experienced a range of techniques embedded in the overall process of therapy. However, they did not comment on techniques in the interviews as the emphasis was on experiencing. This can be thought that perhaps during the therapy the techniques were deeply assimilated as part of the process of therapy (Messer, 2001).

Buffer memories

In the participants' experiences subtheme, "A pathway to the unknown known" is illustrated that the participants used hypnotic phenomena to create a new version of an old experience to ease their pain. This experience is described as similar to an intense dream that we know is a dream. Nevertheless its emotional content can permeate for a while, all of our being after waking up. Participants reported that the affective quality of these experiences were long lasting, and so different to a dream. For example, Lucida reported creating a healing memory of her mother's response to her in her death bed.

The study suggested that hypnotic imagery can be used as a resource towards the memory development of positive experiences and nurturing figure that serve as inner helpers such as "adult mature self" or "ideal parent figures" (Emmerson, 2003; Frederick, 2005). This can be a useful resource for clients. This is congruent with published hypnosis clinical work pioneered by Pierre Janet in 1889. It is similar but more in depth to Imagery Re-scripting within cognitive-behavioural therapy (Holmes, Arntz & Smucker, 2007).

7.4 Findings: Overall reflections

The study findings suggest that clinical hypnosis can be a useful tool in the consulting room. However, there are limitations in the scope of its usage, the main consideration towards the use of hypnosis as an adjunct to therapy, is for the therapist not only to have the knowledge needed in order to apply it correctly but also to be able to use it with a great deal of common sense. This applies to all clinical tools (Rothschild, 2000). I believe that the therapist needs to have

common sense to lay aside or change any method that makes a client uncomfortable. According to Wolpe (1982), a successful client's positive shift is the only justification for continuing with a particular method.

In my experience hypnosis will not be the method of choice for many clients because they do not feel comfortable using it or feel that they are not ready. Other clients may like to use it but find that they cannot because they have very low hypnotisability. According to a recent research (Hoeft et al., 2012), the ability to be hypnotised seems to be a distinct trait (genetic component) that is distributed among the population in a bell curve or normal distribution and so there is a minority of people that cannot engage with any suggestion and will not be able to work in the trance. Furthermore other people are unable to use it because there are contraindications to the use of hypnosis. It is contraindicated for people suffering from severe psychiatric disorders. It is also contraindicated for clients who suffer from dementia, very young children, and people under the influence of recreational drugs and alcohol, or suffering with severe asthma, serious heart condition and epilepsy (James, 2010).

When reflecting overall on the data it seemed that the participants' trauma related embodied mental action tendencies in the shape of emotional reactions, thoughts, images, body sensations, self-believes and movements, kept emerging spontaneously during the trance telling a story and seeking attention. The participants appeared to be suffering from a debilitating, repetitive recapitulation of internal and external relational interactions that were keeping the past present via enactments, maintaining their trauma related distress and disrupting their

quality of life. It brought alive to me that trauma treatment must address the present, here and now experiencing of the traumatic past, in order to generate change.

It can be thought that hypnosis assisted the participants in healing their structural personality dissociation (Van der Hart et al., 2006). I theorize that it assisted the participants in reprocessing of the material by enhancing the accessibility and intensity of imagery which appears to accentuate in the trance the desired effects of imagery-base resources.

I hypothesize that hypnosis might have helped the participants in engaging the attentional system of the brain by identifying, accessing and focusing on experiences, memories and associated beliefs that required connecting. It helped to connect them, developing ego capacities and ego strength.

On the whole the data made me inclined to agree with Foshua (2009) that healing has been a process of recognition at many levels:

> 'This organismic recognition process occurs in experiential therapy when the moments of fittedness occur between the individual and some process in a dyadically co-constructed environment of safety.' (p179)

Foshua explains that recognition is always "dyadic" in that it involves two things fitting together, but it is not necessarily interpersonal. This is the opposite of what I thought prior to this study. This study has highlighted that the fit can be between self and other, as it was considered to be by the participants during talking therapy. However, it can also be between self and self, or self and process, or self and experience, as was described as occurring in trance work:

> ‘The “click” occurs between what is felt as “me” and “not me” in a way that feels right and allows what was felt as “not me” to eventually become integrated into “me”.’ (Foshua, 2009, p179).

I believe that the study can be viewed as indicating that the presence of a good enough emotionally attuned other was, as described by the participants, the foundation, in the shape of a dyadically co-constructed environment of safety, the secure base. This is a place to erect the scaffolding of therapy so the participants could work at many different levels. The study also suggest that this process can be deepened when concurrently the therapist is attending closely to individual differences, strengths and preferences, such as the clients’ ego strength, window of affect tolerance, their theory of change and their therapeutic needs (Cooper, 2008; Cooper and McLeod, 2011; Norcross, 2011). In my opinion this study suggests that hypnosis can be integrated as a vehicle to potentiate therapy in both the relational field and the specific client’s factors. I believe that in the relational field it can be considered that this study is consistent with the published relational hypnosis clinical experiences that describe trance work as an opportunity for deep intersubjective relatedness experiences between client’s ego states, therapist and client’s ego states and therapist and client. It seems to deepened the overall client and therapist field of ‘I-thou’ organisation, the attachment field (Gilligan, 1987).

7.5. Limitations of the study

A limitation of the present study is that the participants could have had concerns about expressing negative opinions about the therapy, thus affecting the validity of the findings. This was minimised by employing an independent interviewer. Participants also had the opportunity to reflect and comment on the final draft of the findings, to someone other than the researcher, who was their former therapist.

They had the opportunity to forward their comments to the research supervisor in Metanoia. However, this way of commenting on the findings was not used. It suggests that they were able to critique their therapeutic outcomes and therapeutic process fairly freely.

The impact of my prior role as therapist to the participants is difficult to establish, but a comparison of my findings from this study with similar studies (Howe, 1989, 1996; Singer, 2005) indicates that participants do voice their content or discontent as consumers of therapy. His would suggest that our prior contact had minimal influence on the positive reports of therapy that participants gave, but we can never be sure.

I faced a number of challenges during the study. The first one took place very early on and it was an ethical dilemma in connection to the recruitment process that resulted in rejecting seven potential participants. With hindsight I think I could have approached the recruitment of participants in a slower and more thoughtful manner in order to reduce the number of rejected participants. I had not anticipated the level of positive response. However, I assume that no damage was caused by the rejection. I took time to carefully explain to rejected participants that there has been a greater than expected level of response, and I could not manage to interview everyone who came forward to participate. Also, my research supervisor's details were listed for anybody who wanted to talk or express concerns about any aspects of the research. No one used any of these.

I think that perhaps it can be considered that there was a selection bias within my sample. It is possible that my data comes only from those participants who found therapy useful. It can be thought that I needed to know more about the experiences of the people who did not want to take part even when the reasons given for not participating were all practical reasons. I do not think that I can attribute their not volunteering to participate to the fact that they might have been uncomfortable with hypnosis as they all have stayed in therapy with hypnosis for over than three months, and they could have abandoned the therapy at any time. They might also have found therapy helpful but did not feel they wanted to re-visit their issues in the interview and did not want to say so. Equally, perhaps the practical explanations given by them for not participating (e.g. moved out of London, had a baby and so on), were the actual reason for not participating. It is also possible that the clients who decided not to take part were less satisfied with their therapy.

This study may be limited therefore in that it has focused on clients with exclusively positive experiences of therapy. I will never know. In any case, this sample can be described as a purposive homogeneous sample congruent with IPA. Overall the study yielded rich experiential material from ten clients that benefited from the therapy with hypnosis. It presented a detailed analysis of the elements of the participants and therapist reflected personal experiences.

I intended the study to allow the reader to see the worlds of the participants during therapy through their eyes. During my interpretative dialogue with the data, I have presented one possible interpretation based on my therapeutic approach, the same approach that the participants experienced during their therapy. I am also

aware that the findings of this study have emerged in a specific context. Another researcher from a different approach, for example Cognitive Behavioural Therapy (CBT), would have interpreted the data differently. Had the study been undertaken at a different time, with another set of participants from my own practice, this could have produced different findings. Life world research cannot offer certainty, as Dahlberg, Dahlberg & Nyström, (2008: 94) said "researchers need to be careful not to make definite what is indefinite". Despite these complexities, the paradox is that the low-hovering, the in-dwelling in the ten participants' lived therapeutic experiences has produced rich experiential material, offering insight into the usage of clinical hypnosis and experiential knowledge on learning from one's own clients in a way that goes beyond the anecdotal. I think this knowledge can be transferred to therapeutic settings similar to mine.

7.6. Future research

Further phenomenological research from the client's perspective is needed to evaluate the impact of integrating clinical hypnosis into different therapeutic settings. Hypnosis is already being integrated into other approaches (Fitzgerald-Pool, 2005), for example in CBT (Alladin, 2008, 2009), attachment based psychoanalytic psychotherapy (Ben-Shahar, 2008) and gestalt therapy (Kepner, 2003). However, no phenomenological research from the client's perspective has taken place to illuminate what goes on for them. In addition, future research with a wider range of clients seems to be needed. For example, a comparison between: male and female experiences, clients from different socioeconomic backgrounds and clients from different ethnic origins. I think that it would be useful in order to understand if and how clients' experiences may vary according to these different

contextual factors.

This study illustrates the integrative use of hypnosis to adults with trauma and stressor – related history that presented with specific conditions and not to other populations. Therefore, study of the application of the combined approach (talking therapy and trance work) to other adult populations as well as to children, couples, and families might further elucidate the potential benefits.

The study did not explore the potential benefits of this therapeutic model on participants on the low end of the hypnotisability spectrum. I think that there is also a need for future research with people for whom hypnosis is minimally effective or not effective in order to understand the conditions and context that make it useful. Research shows that there is a genetic component to hypnotisability as a trait. Studies indicate (Hoeft et al., 2012) that highly hypnotisable people show structural and functional differences in the brain when compared to low-hypnotisable, but it does not answer why we have a varying capacity to have our reality altered by suggestions. It also does not explain the different outcomes of people with high hypnotisability when treated for the same problem by a different therapist.

I believe that perhaps a grounded theory approach could generate theory on the nature of hypnosis and explain more the effect of different therapists on client's outcome. My experience with clients and current hypnosis research suggests that clinical hypnosis involves the utilisation of metaphors and images, closer to what is thought of as the language of the right brain. It suggests a pathway of right brain to right brain communication between the client and the therapist. The

therapist's hypnosis styles have been found to resemble the patterns of basic intimate relationships that have mutual regulatory functions (Bányai, 2006). This led Bányai (2006) to propose a social psychobiological model of hypnosis, conceptualising hypnosis as an altered state of consciousness that may have a socially and biologically adaptive value. These propositions require qualitative research exploration.

8. Conclusions

The participants found the overall therapy beneficial. They reported that they recovered from the distress that brought them to therapy but also experienced a personal growth that improved their quality of life.

This study supports a collection of existing theories regarding how clinical hypnosis may enhance treatment effectiveness for some clients in certain conditions and that it can be incorporated into different depths of clinical work by counselling psychologists and psychotherapists. It also suggested a range of specific ways of how it can be a useful adjunct to therapy.

The findings also suggest that there seems to be a necessity for therapists, regardless of their school of thought, to consider the views of their clients, the recipients of therapy as significant contributors towards the progress of their own therapy. In particular they need an ongoing session to session subtle negotiation regarding the direction of the therapy. This has implications for the way we work and for the integration of research into practice.

The findings underscored the importance of qualitative phenomenological research from which therapists can learn from client's experiences beyond the anecdotal. It has provided an opportunity to learn what really is experienced by clients in therapy and not what therapists think is being experienced.

I was struck by my former clients, the participants of this study, in terms of their tremendous resourcefulness in seeking consciously or out of awareness what they needed from the therapy. It also brought alive to me that in order to deepen their processes, they needed me to be present, emotionally attuned enough in a safe contained relational environment and not to hold a rigid agenda for therapy.

The study also highlights the necessity of integrating counselling psychology, psychotherapy and hypnosis knowledge, to develop knowledge and practice.

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APPENDICES

APPENDI X 1: Ethical approval

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Yolanda Renjifo
47 Redcliffe Road
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London, SW10 9NJ

12th June 2009

Dear Yolanda,

RE: A phenomenological exploration: Towards the integration of clinical hypnosis into an Integrative Relational Developmental therapeutic approach: Learning from my clients.

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please discuss these with your research supervisor in the first instance, and inform the Chair of the Research Ethics Committee, Dr Patricia Moran.

Yours sincerely,

Professor Vanja Orlans
On behalf of the Chair of Metanoia Research Ethics Committee
Joint Head of Integrative Department and Programme Leader, DCPsych
Metanoia Institute

Registered in England at the above address No. 2918520
Registered Charity No. 1050175

APPENDIX 2:
PARTICIPANTS' INTERVIEW QUESTIONS GUIDE

The questions need to be as wide and open-ended as possible for the participants to engage in a phenomenological exploration of their lived therapeutic experiences.

Experience prior to therapy
What brought you into having therapy?
What did you think about it?

Process of therapy
I understand you had therapy in the trance using hypnosis, and not in the trance - talking therapy – in every session?

Please tell me what you experience when you are undergoing hypnosis?

Please tell me what it is like to work on your inner issues in the trance?

What did it mean to you that you have experienced that?

Describe with much detail as possible. Please give examples.

Did it help you in any way?

What was it about working in the trance that made a difference to you?

How did you experience the relationship with your therapist? Were there any differences when working in the trance?

The same guideline of questions as above for "talking therapy".

Post-therapy/ reflections
What, if anything, changed for you through having therapy?

Prompt Anything improve/get worse? How?

How do you feel about yourself after your therapy?

Is there anything particularly important that you think that you have achieved in your therapy?

Is there a metaphor or image that you would use to sum up the essence of your experiences in the therapy? And when working in the trance as compared to not in the trance?

Is there anything else that you would like to add?

APPENDIX 3:

THERAPIST' INTERVIEW QUESTIONS GUIDE

The questions need to be as wide and open ended as possible for the therapist to engage in her phenomenological exploration of her experiences of the participants experiences of therapy.

Experience prior to starting therapy
What do you think brought the participants into having therapy?

Process of therapy
What do you think was the participants' aim of therapy and how they went along to achieve it?

I understand that they had therapy in the trance using hypnosis, and not in the trance - talking therapy – in every session? Please comment.

Please tell me what you think they experienced when undergoing hypnosis?
What it is like for them to work on their inner issues in the trance?
What did it meant to them?

Describe with much detail as possible. Please give examples.

Did it help them in any way? What do you think it was that made a difference to them?

How did they experience the relationship with you as their therapist during talking therapy? And when working in the trance?

The same, as above guideline of questions for "talking therapy".

Post-therapy/ reflections
What, if anything, changed through having therapy? How come?

Prompt – anything improves/get worse? Understanding as to why?

Is there anything particularly important that you think they have achieved in their therapy?

Is there a metaphor and image that you would use to sum up the essence of your experience of the participants' therapeutic experiences? And when working in the trance as compared to not in the trance?

Is there anything else that you would like to add?

APPENDIX 4:
AUDIT TRAIL

APPENDIX 4a:
Example of data analysis

Analysis from Willow's interview

Emerging themes	**Quotation from Willow's interview**	**meaning units**
Prior to therapy Depressed Blamed flawed self for negative events Failed self Cannot cope Sought therapy to regain happier self.	I was very depressed, kind of a combination of being... I had just come out of a not a very good relationship, and I was really frustrated professionally. And I was really in a bad situation with my job, and so just feeling very depressed very down on myself. I think that I felt like, I guess I felt like there were some aspects of myself that had brought me to that situation. You know, that I had like failed in some way and that's why nothing was going right. I just found it more and more difficult to just cope with things and I felt like you know, I wanted to get back to the person that I was before. You know when I was feeling good and happy, and all my thoughts and imagery need to go and talk to somebody and to get myself back on track.	Was depressed Negative situation Self blame Failed self Cannot cope Had memories of happier self Needed help
Therapy meant a changed person. Felt change as a movement from depressed weak self to a stronger self. Moved away from depression. recovered zest for life. Developed resilient self. A better way of being in the world. .	I feel like a different person really um. I mean I think about the way that I was before I came to see Yolanda and it was just a really weak stage in my life. I just like felt terrible. I don't think I have ever felt quite that depressed and down about life, because I think I have always generally been a person that you know could see the light at the end of the tunnel and think OK things are really awful now, but it's going to be OK. Things are getting better. And I couldn't see how things were going to get better and I think I have regained that optimism and I've regained that sort of fire in my drive that joie de vivre that I had before everything happened that brought me to that really depressed state. But, I have that, I have that same confidence and that same kind of excitement for life that I had before, but on top of that I feel that I have the ability now to, if I start to feel bad or if I start to feel depressed again, I have the ability to take care of myself and not let it get me down in the way that it did before I came to therapy. I know how to kind of like protect myself and look after myself in a better way. .	Feel changed. Prior to therapy felt depressed in a weak life stage. Had memories of happier self but felt hopeless. Move away from depression Recovered zest for life & self confidence. Developed self protective self.

Significant TW: Therapy process/ tasks: Strengthening vulnerable self; integrating experiences & affect from the past. Felt achieved understanding & Integration of dissociated experiences.	The most important work that was done in the trance? I think the inner strength work definitely. Um we did work as well where we explored certain events, um from my adolescence and my childhood that were very emotionally loaded. And in the trance she was able to, she helped me to integrate, and I think that process was done in a way that I hadn't been able to process them before um. So for me that was very important because I think I was able to by, I think processing those events, this helped me to understand why I reacted to certain situations in the way that I did.	Significant therapy tasks in TW : inner strength & processing,& integrating emotionally loaded past. Processed un-process past experiences. Learned how the past affected the present.
Developed reflective self. Ego strengthened via self created imagery work/ tool/TW. Long lasting images from inner self healed vulnerable self.	I was able to understand and have the self awareness and be able to deal with it in a better way and then yeah... like I said, the inner strength work was very, very helpful, because a lot of the imagery that came out, like I said, has really stayed with me and has been very powerful and very effective in tackling a lot of the issues with the former vulnerability that I had.	Self understanding. Worked on inner strength TW: imagery came in & stayed. Healed vulnerable self.
	What else have you achieved?	
Outcome felt beneficial: Integrated the past, connected & expressed dissociated anger, closure of a relationship. TW: healing. Ending of unloving relationship tapped on vulnerable self. Blamed flawed unlovable self for abuse. TW: reconnected, redirected & expressed dissociated affect. Justice to self felt healing. Closure. Moved from trapped to freer self	Um. I achieved a lot of integration of certain issues from my past that have affected my behaviour, and we did some work as well with the relationship that I came out of and some kind of energy with the guy in question. Like throw him off the bridge in my mind or something, so that helped me as well. So there was a lot of closure on the situation, and I think particularly in the beginning of the therapy we did. Actually a lot of work in the trance with that, with the guy, and that was very, very useful for me because after the break up and for months I had dealt with a lot of feelings of insecurity. A lot of feelings of inadequacy, due to the fact I think I took a lot of the break up against myself: oh he acted that way because I wasn't good enough. I wasn't pretty enough. I wasn't whatever and through the trance I was able to access a lot of feelings of anger and be angry at him for treating me the way that he had treated me, which was then key to me sort of moving on from the situation. So I was able to feel angry and to understand that that wasn't my fault. He was probably a big jerk, and I used to be upset with him for the way that he behaved and not take it against myself um, and then after that I was able to kind of move on from him and yeah get complete closure from the situation.	Achievement felt positive: Integrated the effect of the past in the present. Expressed anger & emotionally closed a relationship. TW: helped healing insecure, inadequate hurting self. Blamed break up of unloving relationship to not good enough self for abuse during. TW: accessed and directed true feelings from the self to abuser. Self justice perceived as key in moving on. Achieved closure

TT: Good working alliance/ trusting relationship with therapist Process/ tasks: self disclosure reflect insight validated experienced.	Um. Yeah it did, yeah I think, definitely with the therapy. I talked about things that I definitely haven't talked to anybody about in my life, and things that I think I previously had thought "oh maybe is not a big deal or maybe everybody has to deal with" and then talking about that in the context made me think "oh wait, no actually that was quite significant" and played quite a crucial role in how I developed and how I relate to people now and the situation that I am currently in.	TT: Trusted therapist to self disclosure. Validated past experiences. Insight of the effect of the past in the relational present.
TT: Identified issues. TW: worked through issues. Dual therapeutic process. TT: Validated past Locus of insight & reflectivity within the self. Person to person relationship. TW: Worked through integrated experiences.	So I think that with regards to my childhood issues, I think with those, I think we were able to sort of identify, and through the talking process of the therapy we were able to identify them and then sort of work on that and tackle them over during the focused state. So when talking to Yolanda and you know she asked me questions about what happened to you growing up and I was able to kind of think of these things. Um, and then I think, really without sort of any suggestions by her, I would think of that and I would think "oh wait, yeah that really was quite traumatic" and that it quite affected me when I was quite young. And then during the focused work we focused kind of intensely on the events of the situation, and she would kind of help me to integrate them and deal with them.	TT: identified issues TW: worked through them. Therapy processes. TT: Reflected on her own developing own insights, validating past. TW: "we" working together, intensely integrating experiences.
Trance experience varied. Felt dream like state. TW tool imagery. Task/process Worked on protecting vulnerable self/ ego strengthening Created own metaphor: Oak tree.	Um it was very... there were times I think sort of a dream like quality, yeah. I think I mentioned before we did work a lot with imagery so um, you know, one thing we worked a lot was onto building my inner strength and working on protecting my vulnerability. One thing that she say OK "your inner strength, what does it look like? Does it look like something? Does it take on a particular shape or a particular form? Um, and for me, when she asked that question again it always took on the same form like this big oak tree, you know, like really deep roots, and very strong, you know. Lots of foliage and that kind of thing.	TW: images felt sometimes dream like state. Worked strengthening vulnerable part Generated own inner strength image: oak tree
TW: Trance felt: altered consciousness. Power balance felt equal. Felt easy accessing of inner resources/ unconscious processes /long lasting	So yeah, so I think because I was in this sort of semi-conscious state, this kind of, I think it was this knowing we did this imagery work it was easier for me, for those images to come rather than for, you know, in wakeful state and talking to her. I found that sort of after the sessions that imagery stayed with me for a while and it would have kind of... I found that especially with regarding to the inner strength and the tree imagery that, that really stayed with me in difficult	"We" work together. Altered consciousness made it easy for images to come in. Images created were long lasting. Tree image stayed, helped to manage

The magic of the mind: Learned to involuntarily bring in ego strengthening resource/chance mental state. Long lasting skill, self empowering TW: Process & outcome meant: reconnecting dissociated self part. Rebuilding the self & integrating to the self. Dual therapeutic process was key in Achieving self confidence & self worth. TT alone would have felt draining. TW experienced as relaxing and effective & motivating. TW felt more effective than TT.	situations and in situations previous to the therapy in my mind that I would have found very difficult or emotionally trying. At some times that imagery just popped into my head and it would be like "oh" you know "oh the tree appeared." It sounds a little weird but it was as if, the tree is here so everything is going to be fine. So, to describe working in the trance? It made me feel I think, it is like rebuilding a part of me that had fallen apart that had deteriorated. Yeah I would say, that's what working in the trance felt like. It was like kind of putting the pieces back. I think, yes that the combination of being able to kind of first like pinpoint the issues and then focus on them intensely, um was really key in increasing my confidence and my feelings of self worth and increasing you know, increasing my inner strength. Um yeah like I said, I don't know that just I don't know. I kind of feel like if I had just done talking therapy, I kind of feel like I really would have just left here every week feeling like emotionally exhausted and "oh my god". Just to have to talk about all this is so upsetting, "but um having the focused state part as well where I sort of worked intensely on the issues and then kind of came out of it feeling really relaxed. I would leave and feel like "wow this was really great" and I'm going to get better and I'm going to feel better. I already feel better so I yeah, I can't imagine that just talking would have been quite as effective.	difficult feelings. When needed tree image popped into head to strengthen self & changed mental state. TW meant: Rebuilding a fallen self part. Recovering a piece of the self & integrating it. TT& TW together TT: finding issues. TW: working through intensely. Outcome: self confidence & self worth. TT alone would have been emotionally draining. TW felt working intensely but relaxing. Left sessions feeling better and having worked efficiently. TW felt more effective that TT.
TW experienced more effective than TT in transforming the blue print of way of being.	I don't feel like I would have gotten as much out of just talking about it. I don't feel like it would have had the same impact on the way that I relate to people, the way that I approach life now. I do think the focused state was really key. Like I said before, was really key in changing my thought pattern. I don't know, I would love to know how it works so that, on a logical level, you know, it would be cool so that I could put people up to like to monitor their brain activities to see what is it like, what changes, because it changed something for me. It changed the wiring in my brain, I feel like you know.	TW felt more powerful that TT in achieving a change of: relational pattern Way of being thought processes. TW experienced as changing deep brain processes.
Experiencing emotionally attuned therapist positive impact on self. Connection with therapist Underscored lack of it during life	There were several occasions where um I would say something and she would say "oh and that makes you feel like "dadada!" And I would feel like yeah that's it, that's exactly how I felt and it was quite, yeah, it really made a huge impact on me because you don't get that usually from a normal person, from your friends or your family. And somebody can kind of, yeah what you said,	Therapist experienced Emotionally attuned. Impacted self & an process? Trust development? Emotional attuned relationship with therapist felt as a

journey. Showed possibility of new positive way of relating. New positive encoding of attachment.	somebody can anticipate what you're feeling and how that makes you feel, and I think that made me trust her a lot more. I thought yeah, she really understands where I'm coming from and the way I am feeling, like a friend or my mom or my dad, who really don't quite understand me in the same way and were saying "why". So she was giving me something that I don't normally get from talking to friends or something.	new experience during life journey. Felt understood. Emotional attunement a new way of being with others.

APPENDIX 4b: AUDIT TRAIL

Example: Keeping track of the emerging theme at case level

These are all the meanings attached by one participant on a focal point, in this case "trance is". From Willow's transcript, the page and line number permit checking the context against any developing interpretations.

Trance is…

77	starts off … usually focused on a point
58	it felt a bit like guided meditation
62	breathing, relaxing, kind of like clearing your mind
63	focused on particular issues
65	used imagery but it was sort of imagery that I generate
86	a process of deep relaxation and then we start to work.
94	very relaxed very comfortable very at ease
97	it was very peaceful
105	heard nothing other than the sound of Yolanda's voice
112	just really relaxed, just a whole lack of tension
114	my body wanted to kind of relax and be free of tension
123	I was in control of the situation
126	other days where it kind of wasn't quite so deeply into it
136	of deepest relaxation at the point when we did imagery work
138	the feeling that you have before you fall asleep
139	or entirely awake but not asleep … between phases
140	other days I would feel conscious ... depended on the session
151	feeling between, wakefulness and being unconscious.
167	of dream like quality.
175	I was in this sort of semi-conscious state.
176	was easier for those images to come rather than, in wakeful state talking to her.

Below is the summary of the researcher identified cluster of meanings that characterise the content of what for Willow "**trance is":**

Trance felt like guided meditation with a dream like quality.

A very relaxed focused state of concentration with a clear mind.

Trance is experienced in different levels, from feeling conscious to feeling alteration in consciousness; it varies, depending on the sessions.

During trance, work is easy, via mostly self generated visual imagery.

AUDIT TRAIL
APPENDIX 4c:

A participant's table of quotations for master themes & sub-themes

Willow's Table of master themes, sub-themes & quotations

Master themes: THERAPY AS FREEDOM FROM DARK PLACE	**Indicative quotes** **Sub themes:** **A B C**	**transcripts' line number**
A) **In a hopeless place**	Very depressed very down on myself.	31
B) **Trapped spiralling down -vs.- Freer & more in charge**	Nothing was going right and I just found it more and more difficult to just cope. Yeah, I think so I think in a very positive way. I felt really after just a couple of sessions. I felt a lot better about myself, a lot better, a lot happier, a lot more positive and I think I was able to sort of yeah, just be a lot more kind of receptive to people and just friendlier, yeah.	34-35 333-336
C) **A better way of being**	Yes, yeah, well I think so because it helped a lot with the cycle of the negative thoughts and because it increased my self-confidence. I just I was much more pleasant person to be around and much more pleasant to others. Yeah, just all the things that increased self-confidence.	357-360

Master theme: WHAT THE JOURNEY WAS LIKE	**Indicative quotes** **Sub themes: D E F**	**key cross references transcripts' line number**
D) Dual therapeutic process: TW &TT	**Trance and talking therapy complemented each other** I think the combination for me was key, because what I think, I don't think I could have done, I don't know. I don't think I could have done the trance therapy without the talking therapy, but then I think, just the talking therapy wouldn't have addressed my issues in as effectively I guess as the combination.	478-481
E) Working through the past	We explored certain events um from my adolescence and my childhood that were very emotionally loaded, and in the trance she was able to, it sort of helped me to integrate. And I think that process done in a way that I hadn't been able to process them before, um so for me that was very important because I think I was able to by... I think processing those events helped me to understand why I reacted to certain situations in the way that I did.	214-219
F) Learning to control emotions	We did some work on some particularly emotionally difficult issues and we, she would explore with me where if I felt any particular part of my body and during those times I would feel, I would be able to kind of identify where I held that sort of tensions ...I get like tightens up in my chest, tightens like my stomach tightens up and my chest tightens up.	198-206

Master theme: WHAT FELT UNIQUE ABOUT TRANCE WORK	**Indicative quotes** **Sub themes** **G H I**	**key cross references transcripts' line number**
G) **relaxation**	I felt quite relaxed.	64
H) **Access to inner processes & resources**	Very helpful, because a lot of the imagery that came out, like I said, has really stayed with me and have been very powerful and very effective in tackling a lot of the issues with the former vulnerability that I had.	221-224
I) **Working with hypnotic imagery**	We did this imagery work it was easier for me, for those images to come rather than for, you know, in wakeful state and talking to her and I found that sort of after the sessions that imagery stayed with me. I found that especially with regard to the inner strength and the tree imagery that that really stayed with me in difficult situations and in situations previous to the therapy in my mind that I would have found very difficult or emotionally trying and at some times that imagery just popped into my head and it would be like "oh" you know "oh the tree appeared". It sounds a little weird but it was as if, the tree is here so everything is going to be fine.	176-184

Master theme: WHAT MADE THE DIFFERENCE	**Sub themes:** **J & K**	**key cross references transcripts' line number**
J) **Willow's view of change**	I think the fact that it was an opportunity just to focus on certain issues and look at certain issues in a very kind of, I don't know if intense is the right word, but a very, yeah very focused way and to be able to kind of look at them in kind of a non logical way. It sounds very strange, but I think the opportunity to kind of use imaginary and to um find things um you know yeah, to find images that I could use that were analogue to either the issue at hand or to something that would help me tackle the issue was very helpful for me. I don't know if that has something to do with how I am as a person but um, yeah I just felt like it kind of um helped me on a much deeper level than just talking about the issues did.	431-439
K) **Integrating**	Achieved a lot of integration of certain issues from my past that have affected my behaviour and we did some work as well with the relationship that I came out of and some kind of energy with the guy in question. Like throw him off the bridge in my mind or something, so that helped me as well, so there was a lot of closure on the situation.	311-315
Master theme: THE GUIDE	**<u>Indicative quotes</u>** **Sub themes:** **L & M**	**transcripts' line number**
L) **A good relational space**	I immediately from the first session I trusted Yolanda, I felt very comfortable with her. I felt very safe with her.	642-643
M) **Caring therapist**	Like I said before, I have never been in that situation with some one that was that accepting and that un-judgmental and that empathetic yeah.	692-694

APPENDIX 4D: AUDIT TRAIL

Table 5. Master themes for the group

Master theme: **THERAPY AS FREEDOM FROM A SHADOWY MAZE.**	**Indicative quotes** **Sub themes: A B C** **Participants that contributed to theme and sub-themes:** ALL	**key cross references** **transcripts' line number**
A) The self in a hopeless place	Alice: Very, very, very, unhappy, very depressed.	Lucida 35-60 Ken 8-11 Alice 31 George 8-9 Kim 43 Willow 31-33 Chad 15 Mandy 4 Gabby 19-25 Gwen 22-28
B) Trapped & out of control - vs.- Freer & in control	Chad: I cannot tell you how far I have gone, places I never thought I could go. When you are in like a whirlwind and you are depressed, and you think nothing is going to go forward for you, you dig your hole deeper and you don't really think you are ever going to get out. And your negativity takes you over, your positivity goes and the negativity cuts you down and this therapy really changed that.	Lucida 49-53 Ken 450-467 Alice 588-599 George 732-737 Kim 378 Gwen 10-12 Willow 34-35 Chad 386-392 Mandy 29-31 Gabby 484-854
C) A better way of being in the world	George: The thing that came to my mind just then was, um, you know, eh, was a butterfly. So it's almost like coming out of cocoon and, um, it was the breaking free, it was you know, being in this stuck, in this place, in this stasis and it was the gentle breaking and tapping away of the cocoon, and you know eventually this freedom. This freedom which wasn't just in my mind but now is in my life and this ability to fly and do anything I want to do and go anywhere I want to be, and to be beautiful and be, um, special, so that would be my inner dream that came to mind.	Lucida 238-239 Ken 325-327 Alice 819-820 George 855-863 Kim 353-369 Chad 570-573 Mandy 878-882 Gabby 506-507 Gwen 494-502 Willow 600-613

Master theme: **THE JOURNEY'S FELT SENSE**	**Indicative quotes** **Sub themes: D E F** **Half of participants had different views about sub- theme D.** **All contributed to sub-themes: E & F**	**key cross references transcripts' line number**
D) Dual therapeutic process	**Trance as main key to the work** Gabby**:** It is very different cause once you're in trance everything is more heightened more real the emotions um happens very quickly...I think in the trance it is s like hitting the nail right on the head once you're in a trance.	Ken 670-674 Mandy 933-940 George 68-72 Gabby 416-422 Gwen 800-801
	Trance and talking therapy complemented each other Kim: Yeah, I mean anger that sort of thing. There is a lot of anger that I've had to deal with and which is probably what the fear stems from, do you know, just feeling abandoned and that sort of thing and the fear that I have over death probably stems from that. But you can't just do the trance if you don't know what the beginning state is kind of is like going from A to Z. You have to start at A in order to get to Z, and work your way through the letters of the alphabet.	Kim 526-530 Chad 691-695 Lucida 479-485 Alice 683-687 Willow 478-481
E) Meeting the shadows	Lucida: One of the most important aspects of the therapy was to enable me to grieve for my mother and a chance to try and resolve, although I know it is not always possible to rid yourself of things. You are haunted by it for years. I think it has always been there, I needed to grieve so that I could go forward, and I was able to do that in the trance.	Ken 188-193 Alice 328-335 George 345-352 Kim 271-285 Willow 214-218 Chad 355-363 Lucida 232-239 Mandy 521-526 Gabby 597-603 Gwen 85-92
F) Surfing the waves	Mandy: Yolanda Can take you back into those senses, hysterical feeling. Um, make you re-live it and at the highest point um try and make you break that somehow. It's almost like reliving the experience again um and then exerting your own sense of control over it. By breaking it. So, um, kind of retrospectively breaking the control. Strange.	Lucida 13-616 Ken 477-479 Alice 779-785 George 495-499 Kim 438-439 Willow 169-170 Chad 369-375 Mandy 803-805 Gabby 599-601 Gwen 845-848

Master theme: **UNIQUENESS OF TRANCE WORK**	**Indicative quotes** **Sub themes: G H I** Participants that contributed to theme and sub-themes: ALL	**key cross references transcripts' line number**
G) **Profound relaxation**	Kim: Complete calmness, which is not something that I had experienced because I was `dealing with quite a bit of anxiety and that sort of thing. So it, it was um, sometimes it was a bit emotional for me to allow myself that, you know.	Lucida 126 Ken 81 Alice 46 George 116 Kim 141 Willow 64 Chad 373 Mandy 178 Gabby 451 Gwen 110
H) **A pathway to the unknown known**	Mandy: I had a real sense of awkwardness. A real sense of umm, of inhibition basically. I think that to sit here to discuss how I was as a child. Actually it is just easy to say I was like this or I was like that, but I didn't realise I was until I was in the Trance. That is the thing. Those things didn't come up until I was in the Trance. So I wasn't conscious of them. So if I were to sit here with Yolanda and talk as I would with a normal counsellor I would never have mentioned my childhood and how that can possible impact bulimia. I didn't think anything of that it is only when I was in the trance that I started to go back to all this different things different images of childhood that I have never seen before that I realised that the issue with my dad was so clear.	Lucida 131-134 Ken 266-271 Alice 328-335 George 326-331 Kim 261-264 Willow 214-219 Chad 99-104 Mandy 330-340 Gabby 85-89 Gwen 48- 59
I) **The magic of the mind**	Ken: I had an image of my Mum, and I could talk to her and give her a hug and say why I can't do it, because sometimes it's easier for me to say it when I'm on my own. Once I have her physically I couldn't, I couldn't. Um in a trance I spoke with my Mum and you know I gave her a hug and it was really real.	Lucida 159-164 Ken 222-223 Alice 362-363 George 287-302 Kim 659 Willow 176-184 Chad 334-338 Mandy 266-273 Gabby 501-509 Gwen 199-202

Master theme: **WHAT MADE THE DIFFERENCE**	**Indicative quotes** **Sub themes:** J K L Participants that contributed to theme and sub-themes: ALL	**key cross references transcripts' line number**
J) Participants' theory of change	Chad : It gave me impetus. It was like a foundation that was not going to give me the answers to everything. It would give me possible solutions but um, they only became solutions when I would test them outside in the real world. Or I would listen to my gut, or my intuition that what I got from the trance, and I would use that in the real world. It would imprint something in me and it would enable me to continue move forward and to be more hopeful and more positive.	Lucida 415-430 Ken 683-688 Alice 631-649 George 448-458 Kim 334-337 Willow 431-439 Chad 650-655 Mandy 419-423 Gabby 616-618 Gwen 93
K) From dissociation to connecting	Gabby: It made me grow up a lot, cause now when, I speak to myself, I see myself as a grown up. Before I didn't know how old I was, young, my, my birth certificate says what but mentally I was, all over the place. I had problems of um, as I said, coming to womanhood and just like, I was a bit like um a little um animal. I don't know don't know where to turn so things. I have grown up and um to a woman and be able to stand up for myself or to know that I'm good, you know that, I am not a failure cause I always see myself, saw myself as just a waste of space and that's what I used to tell myself. So I don't call myself names anymore... You know so there is no longer the anger towards myself, um so I think so definitely when we integrated the teenager self with the grown up Me.	Lucida 303-313 Ken 640-642 Alice 650-653 George 326-331 Kim 409 Willow 311-315 Chad 543-546 Mandy 256-268 Gabby 703-714 Gwen 93-99
L) Reflecting & Experiencing	**Reflecting** Lucida: I suppose it is about self confidence and self love, and I think learning nurturing little Lucida seeing her as this beautiful little child; happy, so happy which as a child I wasn't. I know I wasn't and also in the fully awake state to get the support of the therapist to help me to believe in myself. That I could do it, really, that is what it is, about self- belief and self- love and because I realised that I am afraid a lot of my mistakes have come from my relationships with women.	Lucida 420-427 Ken 321-328 Alice 565-573 George 424-431 Kim 427-432 Willow 317-323 Chad 570-573 Mandy 815-822 Gabby 36-41 Gwen 90-96
	Experiencing Lucida: I have to say it has been emotional for me there have been tears. I feel tears of happiness. It has been a very moving experience very hard to put it words um is the foundation that I needed, I needed that foundation um.	Lucida 613-616 Ken 221-224 Alice 628-631 George 344-352 Kim 454-457 Willow 199-206 Chad 334-341 Mandy 97-100 Gabby 548-555 Gwen 216-218

Master theme: **THE GUIDE**	**<u>Indicative quotes</u>** **Sub themes: M & N** **Participants that contributed to theme and sub-themes:** ALL	**key cross references transcripts' line number**
M) **Someone is looking after you**	Gwen: She (therapist) was very caring, very attuned, actually, um, very perceptive I would say.	Lucida 217 Ken 344 Alice 885-888 George 619-621 Kim 674-676 Willow 675-684 Chad 775-776 Mandy 373-375 Gwen 954-955
N) **A good relational space**	Gwen: I feel very safe um because you're aware, still aware of where you are in one sense but in another sense you're sort of going on a journey, um as well, which Yolanda is very supportive with and she's sort of there with you all the time um as a guide.	Lucida 232 Ken 345 Alice 369-370 George 615-618 Kim 684-687 Willow 898-901 Chad 368 Mandy 372-373 Gwen 110-114